

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF MATERNAL, CHILD AND FAMILY HEALTH
Bureau of Family Health

MCH PROGRAM GUIDANCE

FOR

FFY 2003 Maternal and Child Health Contracts

Effective Dates: October 1, 2002 to September 30, 2003

PROGRAM GUIDANCE
For Establishing Outcome-Based
FFY 2003 Maternal and Child Health Contracts

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PROGRAM GUIDANCE
For Establishing Outcome-Based
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Section 1: Background

A. Introduction

This document begins with a summary of the design of the MCH program contract and includes an invitation for proposals for funding from local public health agencies. The FFY 2003 contract continues as a fixed-price outcome-based contract.

Prior to the outcome-based contract, the MCH contract focused on delivery of MCH related activities and how the money is spent. The contract was not focused on health outcome improvement or whether the dollars spent achieved outcomes worthy of the expenditure. As long as the activities followed the work plan and the expenditures follows the budget, the money continued to flow. Health outcomes were not related to money spent.

The Missouri Department of Health and Senior Services (Department) made the decision to change how it does business. There is a double focus in the shift. The first is a general movement away from contracts based on cost-based reimbursement and toward performance-based or outcome-based contracting.

The second, and primary focus, is to build and maintain a strong system of care to provide core public health functions. To be strong, the system must have six basic components. Those components include the capacity to: 1.) Identify problems and solutions; 2.) Continually assess and monitor identified problems; 3.) Plan and maintain referral systems; 4.) Assure people are in place who can effectively address needs and assure that regulations are followed; 5.) Provide education in order to identify problems and solutions; and 6.) Evaluate how the system is working and use that evaluation information to improve the system.

The core public health functions are central to developing and maintaining a system to coordinate services to meet the needs of a community. No matter whether an issue deals with communicable disease, safety, teen pregnancy or health care for children, when the system is in place, issues will be recognized and dealt with appropriately. Service coordination is 'the glue' that makes the system work seamlessly.

Maternal and child health is just one part of this public health system. This contracting method, "fixed price outcomes-based," proposes to establish an MCH service coordination system, partially funded through Title V Block Grant dollars. The local public health agency (LPHA) will contract to build and maintain this system within their county or city, using a contract that includes certain outcomes.

The advantages of this contract type include more flexibility in using funds, far less paperwork, and more local decision-making. One of the primary reasons for beginning this change in contracting method is to support the LPHA in their assurance role through Title V Block Grant funding.

Section 1: Background *(Continued)*

B. Appreciation

This contract design was reached after several months of discussion with numerous Department staff and representatives from LPHAs. Special thanks goes to representatives from the Director's Advisory Council on Local Health and representatives from Department for the many hours given to this effort to discuss and comment on this design.

C. History

This change in doing business is happening across the nation, not just in public health, but in all facets of government. As public health dollars become more scarce, it is increasingly important that each dollar be used prudently. Several factors contribute to and support this change in the MCH contract.

GPRA: The federal Government Performance and Results Act, known as GPRA, took effect, government-wide, in 1997. To meet the challenges, all levels of government need to maintain high-performing organizations, to focus on performance management and to use effective methods. GPRA is a tool Congress created to focus the budget process on results, rather than merely good intentions.

The GPRA structure of strategic plans, annual performance plans and annual performance reports is a framework for integrating planning, budgeting and accountability processes. This calls for more efficient organizations at all levels of government. To meet the challenges, all levels of government will need to maintain high-performing organizations.

Healthy People 2010: Along with GPRA and the focus on outcomes, the Department is committed to the Healthy People 2010 goals and objectives. Achievement of objectives is dependent on health agencies in all levels of government and non-governmental organizations to assess objective progress.

HRSA: The Health Resources and Services Administration (HRSA), a lead Federal agency in promoting improvements to the Nation's health, has one primary goal. The goal is access to care for everyone. HRSA has four strategies to support this goal: 1.) Eliminate barriers to care 2.) Eliminate health disparities, 3.) Assure quality of care, and 4.) Improve public health and health care systems. The work is carried out through HRSA programs that provide funding to the States.

The Maternal Child Health Bureau (MCHB) Block Grant Program is one of their programs. The MCHB began using performance measures in 1997 to orchestrate their partnership with the States.

Missouri's Experience: Between 1999 and 2001, the Department has structured the MCH contract around the MCH Block Grant 1997 performance measures. Contracts were based on local activities to support selected performance measures. Budgets were developed, activities were completed, money was spent and expenses were billed to the Department. Within those cost-reimbursement contracts, the focus has been on whether the pre-agreed upon activities were completed, whether the money was spent as defined in the contract, and whether all the money was spent. This method of contracting created an administrative burden for everyone involved. Despite all of the effort involved the health indicators for Missouri are failing to improve significantly. The next logical step for Missouri was to re-examine how we are addressing the MCH needs.

Section 1: Background *(Continued)*

Next Steps: The Department needed to move toward more functional performance measure outcomes. The new design of the contract for the MCH Program is focused on creating a stronger MCH public health system in order to achieve improved outcomes. To operationalize this design, the MCH contract is now a fixed-price and outcomes-based contract.

During the development of this contract model, two questions consistently occurred: “What will the effect of the fixed-price outcomes-based contract be on public health in Missouri? How do we best go about creating an MCH contract for Missouri?” Nationally, cookie cutter models for “how-to-do-it” do not exist.

To answer these questions, the Director’s Advisory Council on Local Health selected representatives from each district to partner with the Department in an advisory capacity. Department staff gathered information from various sources to help design the best model for Missouri. Numerous meetings occurred over a one-year planning period to design the MCH system.

Philosophy Behind The MCH Service Coordination System: Improved health outcomes can best occur when the community works together to assure that women, children, and families have access to needed personal and population-based health services. To assure a strong responsive MCH health care system state-wide, efforts need to be focused at three levels: when working with just one person or family, when looking at the needs of the entire population, and when addressing the public health infrastructure system level.

Certain mechanisms are needed to take care of all three levels: sharing information about health care issues with the public; assuring accountability and providing population-based preventive services; and tracking and follow-up to help secure adequate health care for women and their families.

The MCH service coordination system has six components. These components: identification, assessment, referral, assurance, education and evaluation support this philosophy and also support the core public health functions.

Service coordination is the key factor required in order to build a strong system that addresses the needs of individuals, the population-base and the infrastructure of the health care system.

Ten Essential MCH Functions: One of the changes in our national health care system in recent years is the increased attention to integrating health care delivery networks. The core public health functions of assessment, policy development and assurance were defined. Along with the core public health functions, essential public health services to improve the health of the entire population have been identified to meet national health objectives.

National MCH leaders defined the elements of public health systems and services that are needed to assure the appropriate focus on the needs of women, children and youth. To enhance the public sector capacity to respond to the unique needs of this population, essential MCH functions were defined.

The framework of the essential MCH functions operationalizes the core public functions in the context of maternal and child health. It gives local, state, and federal MCH staff a tool that can be used to plan and develop stronger MCH health care systems. It is upon this framework that the new MCH contract design is based. A summary of the Public MCH Program Functions Framework was provided during initial discussions of the new contract design.

Section 1: Background *(Continued)*

Within this philosophy, there is a strong focus on meeting the needs of all children with a special health care need. Service coordination within the MCH system includes addressing children with special health care needs.

Section 2: Terms and Conditions

A. Intent of Invitation For Proposals (IFP)

It is the intent of the Missouri Department of Health and Senior Services (Department) to enter into a contract to establish within each local public health jurisdiction; an integrated multi-tiered (direct, population-based, infrastructure) service coordination system capable of adapting to address targeted maternal-child health issues.

B. Purpose of the Solicitation

The purpose of the Maternal Child Health (MCH) contract is to provide funding to be used solely to benefit residents of Missouri. Through this contract, the Department and local public health agencies are able to work together to improve the health of Missouri mothers and children through fixed-price outcome-based contracts.

C. Program Structure

The MCH Program operates under the supervision of the Missouri Department of Health and Senior Services, the Division of Maternal Child and Family Health, the Bureau of Family Health and the MCH Program Manager.

The Department implemented the fixed-price outcome-based contract model to reduce the emphasis on process and input, while increasing the focus on outcomes. Outcome-based contracting becomes a tool for quality improvement, performance assessment, and accountability. People and organizations with targets tend to outperform those without them. There are several advantages for shifting to this method of contracting:

Fixed-price outcomes-based contracting will minimize centralized management by the funding agency and rigid rules.

- Outcome information can assure funders and the public that investments are producing results.
- Agreement on desired results can facilitate cross-system collaboration on behalf of children and their families.
- Information about results enhances community and agency capacity to judge the effectiveness of their efforts. The community can understand whether their programs are having the desired impact.
- A focus on results clarifies whether allocated resources are adequate to achieve the outcomes expected and may more realistically limit the number of outcomes that can be achieved.
- Accountability, with flexibility, to manage the program.

Section 2: Terms and Conditions *(Continued)*

The intent of the MCH contract design is for LPHAs to be accountable for making progress, and create a way for the LPHAs to have the flexibility to manage their MCH activities and funds to meet their local needs.

To do both of these things, the MCH contracts treat funding in essentially two categories – a guaranteed or “assured” category and a provisional category. These provisional funds represent a flexible funding base that can be positively affected by performance. As such, this category presents an opportunity for contractors to increase their funding for the following year.

D. Letter of Intent

The Department by 3 p.m., on May 1, 2002 must receive a letter stating the LPHAs intent to respond to the Invitation for Proposal, or decision to not submit a proposal. Letters should be prepared on agency letterhead, contain an authorized signature and be submitted by personal delivery, mail or fax to:

MCH Program Manager
Missouri Department of Health and Senior Services
Bureau of Family Health
920 Wildwood Drive
P.O. Box 570
Jefferson City, MO 65102

E. Core Elements of the MCH Contract

- 1.) Service Coordination:** The Case Management Society of America defines “case management” as, “A collaborative process which assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet an individual’s health needs, using communications and available resources to promote quality and improved outcomes.” Case management is a term with a more clinical focus, but the definition relates well to the new MCH service coordination system.

Service coordination is the glue that makes the system work well for clients, for provider groups, and for the whole community. Good service coordination may point to needs for infrastructure changes at any level. The service coordination element of the contract includes the following tiers:

Direct: The coordination of needed services when working with an individual or family.

Population-based: The coordination functions performed to assure that preventive interventions and services are available for the entire MCH population of the jurisdiction.

Infrastructure: Activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health systems.

- 2.) Plan of Work:** Each MCH contractor will develop a proposed plan of work. The document should follow the outline as shown in Appendix B and be prepared using a font size of no smaller than twelve (12). When completed, the plan of work will become part of the MCH contract.

Section 2: Terms and Conditions *(Continued)*

The plan of work will address the MCH population needs and the service coordination system components of identification, assessment, referral, assurance, education and evaluation. Attention must be given to each system component. Appendix A shows the relationship of the 10 Essential MCH Services to the service coordination system components.

a.) Performance References Spreadsheet: The MCH Performance References spreadsheet, provided to each potential contractor, will contain a listing of 18 MCH performance measures drawn from the Department strategic plan, Healthy People 2010 goals and objectives, and state MCH priorities.

For each performance measure, 1999 baseline data is shown for the State and for the County/City. For each performance measure the spreadsheet contains, annual target projections through the year 2005 for both the state and jurisdiction.

For the FFY 2003 contract, the Department has adjusted the number of problem priority areas to which the contractor must give attention. The plan of work must address a minimum of two and a maximum of four problem areas identified as the targets for intervention in the FFY 2002 MCH contract. The Contractor is cautioned to carefully consider the decision to decrease the number of problem priority areas weighing the inherent contractual obligations and the impact upon the target population. Overall, the Department does not encourage changing identified problem priority areas from year to year. Criteria for selecting problem priority areas to address is as follows:

1. The Contractor may select 2, 3, or 4 of the problem priority areas targeted for intervention in the FFY 2002 MCH contract.
2. The Contractor may substitute a problem priority area that was not targeted for intervention in the FFY 2002 MCH contract for one of the 2 – 4 areas indicated above if compelling evidence exists. Such substitution will be at the discretion of the District Teams.
3. No area identified as “✓” under the column heading “County State Variance” may be selected.
4. No area Identified as “NA” under the column heading “County State Variance” may be selected in instances where the County rate is better than the State rate.

If the Contractor feels a highlighted MCH problem area is being adequately addressed within the community, the plan of work shall provide evidence, to show that other community resources are addressing an identified priority problem as listed on the MCH Performance Reference. The contractor shall explain the current resources committed or potentially available for addressing the priority problem(s) and the contractor’s involvement in the plan for addressing the priority problem.

For highlighted MCH problem areas where the county/city baseline data are not statistically significant, the Contractor may request to target another performance measure without having to provide supporting information. This applies only to performance measures with the notation of “N/S” under the column heading “County State Variance”.

Section 2: Terms and Conditions (*Continued*)

- b.) Other Performance Measures:** The Contractor may request to target another MCH performance measure. The Contractor, with the introduction of supportive data/documentation, may negotiate to address additional or alternate MCH problem areas.

Community information, supporting data, and previously described documentation of how target indicators are being addressed must be prepared to support focusing on additional or alternative problem areas.

For other health indicators, that are “at or better than” the State target rate, the Contractor will maintain the rate at the projected state rate for subsequent years.

- c.) Target Projections:** The five-year target projections on the MCH Performance Reference spreadsheets are calculated for each county/city according to the amount of annual improvement needed in order to meet the 2010 objectives. The target projections are the aiming points in an outcomes-based contract.

Target projections are negotiable during the initial writing of the plan of work. The targets are negotiated in the context of each county/city; no comparison will be made to targets set for other cities or counties.

When negotiations are completed, a District Team member and the Contractor shall sign the Performance Reference spreadsheet. A copy of the Performance References Spreadsheet showing the negotiated target projections shall be attached to the plan of work and will become part of the annual MCH contract.

- d.) Description of MCH System:** The plan of work must provide a description of the existing MCH system for addressing each problem priority area. The description shall define the Contractor's role in the existing system. The plan of work must describe what will be done within the community to address problem areas. The Contractor shall identify and work with appropriate agencies and community organizations to complete the plan of work. Activities for any cross-cutting community program must capture the contractor's unique contribution, and the contribution of other community partners, to achieving an outcome.

Those affected by decisions based on performance measures should share in creating and selecting the outcomes. The focus is on building and strengthening local public health systems of care to provide core functions. Contractors that have a detailed plan of steps to be undertaken are most likely to be successful.

- e.) Evidence-based Interventions:** The Contractor shall use interventions that are evidence-based, field-tested or validated by expert opinion. The Division of Maternal, Child and Family Health has as a goal, that eighty percent (80%) of interventions implemented by its contracts will be evidenced-based.

Science contributes to advances in MCH public health practice. To make the most change in health indicators, use of interventions that are known to work is critical. This contract allows us to adapt expert opinion or field tested interventions to create and/or discover Missouri best practices.

Section 2: Terms and Conditions *(Continued)*

- f.) Outcomes:** The Contractor shall include milestones and short-term outcomes in the plan of work. It would be ideal if the contract outcomes could be long-term changes in the health indicators for the population. However, change in many of the indicators takes several years to accomplish and requires major system changes. Many health indicators would require massive investments, far more than this contract can provide. To meet the challenge of building and strengthening the MCH public health care system; a short-term outcome is much more modest than ultimate health status changes for a population base.

However, the two are linked. The linkage of the 2010 national health goals and the performance indicators for Missouri is what the contract outcomes are leading to. Meeting or exceeding the targets set for the performance indicators is the long-term outcome. The work on these complex issues has to be broken down into manageable pieces.

- Short-term outcomes for the plan of work, must state the behavior change to be achieved in the target population, must be defined in measurable and definable terms, and must be completed within the annual cycle of the contract.
- Milestones for the plan of work must be defined for the contract. The milestones are the critical steps that must be achieved to make a change in the attitude, knowledge and skills in the target population. The attainment of the milestones will lead to meeting the short-term outcomes.

The milestones and short-term outcomes set direction and are a tool for quality improvement, performance assessment and accountability. They are the change measures to make the system work better.

- g.) Timeline:** The contractor shall prepare a timeline for achieving each milestone and outcome. The contractor and the Department shall negotiate the timeline during the initial writing of the plan of work. The focus is on progress toward meeting outcomes.

- h.) 30% Requirement:** At a minimum, 30% of efforts shall be directed toward children with special health care needs. (See definition of children with special health care needs in Appendix H.)

In this contract 30% of the Contractor's efforts must be directed toward children with special health care needs. Efforts directed toward children with special health care needs must be identified in the plan of work with an asterisk.

- i.) Deliverables:** The contract deliverables are the negotiated short-term outcomes.

- j.) Evaluation System:** The Contractor shall provide in the plan of work a description of their population-based evaluation system, which incorporates the MCH priority problem areas targeted for intervention. The proposal must describe the evaluation system used. The system must be one that describes and monitors health events through ongoing and systematic collection, analysis, and interpretation of health data for the purpose of planning, implementing, and evaluating public health interventions.

Section 2: Terms and Conditions *(Continued)*

In order to make operations more efficient, more effective and to achieve continuous improvement, methods to evaluate operations are essential.

- k.) Evaluation and Continuous Quality Improvement:** Defining, measuring, understanding and controlling the processes that constitute public health practice are essential elements of the improvement agenda for the public health system in Missouri. It is the expectation of the Division of Maternal, Child and Family Health, that each of its Contractors shall define and support processes that include the systematic collection of information about resources, activities, target population and intended results. Every system supported by MCH Contractors should be continuously redesigned based on evaluation activities to better achieve those intended results.

Each contractor shall develop and implement a written plan for continuous quality improvement.

F. Federal Funding

These monies are made available through the Title V Maternal and Child Health Block Grant of the federal Social Security Act, in anticipation of FFY2003 Maternal and Child Health Block Grant funding being passed by the U. S. Congress and being available by October 1, 2002.

G. Eligibility

The Department of Health and Senior Services is inviting proposals for funding from local public health agencies. Any local public health agency is eligible. No proposal may cover an area smaller than a county in size with the exception of Joplin, Independence, Springfield, Kansas City and St. Louis City.

H. Procurement Process

The Department will accept non-competitive proposals from local public health agencies for the FFY 2003 contract period. Proposals shall be submitted in response to this Invitation for Proposals. Completed proposals shall be submitted to the MCH District Nurse Consultant for initial review and negotiation by the District Team. Fully negotiated and agreed upon proposals shall be submitted to the Department-Central Office for final review. After the initial screening process of the proposal, the Department reserves the right to clarify or verify any component of the proposal that is unclear. Awards shall be made to the Contractor following completion of an approved proposal. See Appendix B for Guidelines and Checklist for Preparing and Submitting Proposals.

Competitive proposals will be solicited in the following situations: 1.) When a LPHA submits a Letter of Intent stating intent not to respond to the Invitation for Proposals or; 2.) When a LPHA fails to respond with intent to contract. In either situation, the Department reserves the right to request competitive proposals in that jurisdiction. Statewide notification will be made for the request for competitive proposals in any jurisdiction. LPHAs may submit a competitive proposal.

Section 2: Terms and Conditions *(Continued)*

I. Negotiation Phase

For a decentralized MCH contract process to be successful, the Department has established a decentralized process to provide technical assistance to LPHAs and to conduct the initial review of the proposals.

District Teams, composed of the District Health Director, and/or the Assistant District Health Director, the MCH District Nurse Consultant and the District Community Support Consultant, are the initial contact with the LPHA in the development and preliminary negotiation of the contract plan of work. The Department delegates to the District Teams, the initial negotiation of the plan of work between the LPHA and the Department. During this process, the Contractor and the District Team shall negotiate milestones, short-term outcomes, target rates or other items in the plan of work.

Both the District Team and the Contractor must agree to the proposal in advance of the contract process. Once the District Team is in agreement with the proposal, the plan will be sent to the Department for final review.

The negotiation process may begin any time after receipt of the Invitation For Proposals, but must be completed by the date specified in Section Y of this document. Negotiation meetings are by appointment and scheduled through the MCH District Nurse Consultant.

J. Clarification

The Department reserves the right to request clarification of information submitted and to request additional information regarding the proposal.

K. Authorized Signature

The signature of the offeror must be that of a Director or other duly authorized individual of the agency/jurisdiction submitting the proposal. One copy of the proposal must have a manual signature. The additional sets of the proposal may be copies.

L. Award

Funding for FFY 2003 is non-competitive and awarded using a base amount of \$10,000 plus a proportion of total funds based on each county's respective female-child poverty ratio¹.

The award amounts for each county/city (See Appendix C) are calculated based on FFY 2003 Federal funding, the 1990 census, and 1996-2000 birth certificate data.

Award amounts for subsequent years will be affected by the Federal funds available to Missouri and the 2000 census data. The census data poverty information used in the MCH funding formula will not be available for use until the FFY 2004 MCH contract period.

¹ A female child poverty index factor is determined for each county in Missouri by the Center for Health Information Management and Epidemiology (CHIME). The female child poverty index is a composite of 2 factors for each of the 115 jurisdictions: Maternal-infant indicator (births to adolescents, or infants fetal deaths, or low birth weight) and Women (15-44) and children (under age 18) under 185% of poverty. The female child poverty index factor for the FFY 2003 MCH Contract is based upon the most current data available, 1996-2000 period. The total available funding for the contract is then multiplied by the female child poverty index factor and added to the base funding amount to arrive at the total award amount for each LPHA.

Section 2: Terms and Conditions *(Continued)*

M. Joint Submission

Agencies may work collectively in multi-county groups to address needs across a larger population base. In such cases, funding will be based on the total available to the jurisdictions working in the collaborative relationship. Multi-county proposals must address the priority problem areas identified for each jurisdiction and must describe how the contract effort to be distributed among the jurisdictions. One (1) agency must be designated as the Contractor. Letters of agreement are required if there is a multi-county plan of work or if the plan of work involves working with other health departments.

N. Contract

When the proposal is completed and submitted to the Department, the complete proposal shall be appended to the contract as Exhibit 1, and shall be incorporated as an integral part of the contract.

O. Contract Model

Beginning in FFY 2003, the MCH Outcome Funding Plan ties performance to contracting decisions through the use of performance incentives. The contractor will be accountable for achieving the negotiated outcomes. The Contractor and the Department shall follow the MCH Outcome Funding Plan for FFY 2003 and successive years of the contract. (See summary in Appendix D)

In the event that a contractor is not making progress on the plan of work defined in the contract, the contractor will be given technical assistance to help determine how to get back on track with the plan of work or whether re-negotiation of the proposal is needed.

The individual contract amounts will be divided into two fund categories; Assured Funds and Provisional Funds. In FFY 2003, 60% will be in the Assured Funds category and 40% will be in the Provisional Funds category. Payments to contractors will be paid out in equal monthly payments using funds from both categories. The first incentive applies to incentives for the contractor to retain Provisional Funds.

During the negotiation phase, the Contractor will negotiate conditions for each short-term outcome in the contract. The conditions may simply be viewed as the contractor's confidence in being able to achieve their short-term outcomes. The conditions are a reflection of the LPHA's expectation of their own success.

The conditions will be locally determined based on measurable short-term outcomes established during negotiation between the LPHA and the District Teams. Each proposal is discussed and negotiated solely on its own merits.

During the negotiation, the question to be answered is "How high is the likelihood that the contractor will achieve the short-term outcome?" The relationship between the achievement of short-term outcomes and the expectation of success will depend on a variety of local factors.

A percent of confidence is negotiated and attached to each short-term outcome. The percent of confidence can be no lower than 5% for any short-term outcome. The dollar value attached to each short-term outcome is the percent of the Provisional Funds category only.

At year-end, if all short-term outcomes are met, the Contractor retains all Provisional Funds. If a short-term outcome is not met, then adjustments will be made based on the negotiated

Section 2: Terms and Conditions (*Continued*)

percentage. The Contractor has the choice of having the adjustment made from the final payment, or from the Assured Funds category in the next year's contract award.

The Performance Measure Targets, the short-term outcomes and the conditions for Provisional Funds are all negotiated and agreed upon by the Contractor and the District Team. The intent is that each contract to be achievable in order to support each Contractor to be successful.

Over the next four years (FFY 2004 – FFY 2007), the amounts in each fund category will change 10% each year. The amount in the Assured Funds category will be decreased 10% each year. The amount in the Provisional Funds category will be increased 10% each year.

The second focus of incentive is attached to making a change in the Performance Measure Targets. Because of the amount of time it takes to change health status indicators, the targets will be assessed following the initial three years of the new contract design (FFY 2002 – FFY 2004). An Incentive Award will be made based on a formula. A portion of the formula will be the percent of improvement in the identified performance measures. The Incentive Award will be allocated to the Contractor's Funds Assured category for the following contract year.

The money for Incentive Awards will come from two sources. The first is funds that were allocated to a LPHA/jurisdiction that chose not to participate in the FFY 2003 and FFY 2004 contracts. The second source is the contract funds accumulated through Provisional Funds returned in FFY 2003 and FFY 2004. Beginning in FFY 2006 the incentive pool will be based on those funds, if available, from the previous contract year.

The conditions for receiving an Incentive Award are: 1.) The negotiated Performance Measure Targets cannot have changed during the previous three years, and 2.) The Contractor has met or exceeded the Performance Measure Target.

Whether there are funds in the incentive pool or how much money is in the incentive pool is an unknown. It is desired that every LPHA participate in the MCH contract and achieves all short-term outcomes. Assuming both of the above occur, there may not be an incentive pool.

Beginning in FFY 2003, the outcome-based contract will also take into consideration other performance aspects of the Contractor. In addition to achieving all of the short-term outcomes, the contractor is expected to submit all reports and invoices by the contract deadline, and attend a District meeting to officially open the contract. If all short-term outcomes are not met, or all reports and invoices are not submitted by the contract deadlines, or the Contractor does not attend the entire contract opening meeting, the Contractor will be placed on a Conditional Contractor List the following contract year. They will remain a 'conditional contractor' for one contract year.

During the conditional year, the Contractor may improve their performance and have the conditional status removed. If the above requirements are not met during the conditional year, competitive proposals will be solicited the following year for the identified jurisdiction. The LPHA may submit a competitive proposal.

If the Contractor has made no positive change in the Performance Measure Targets by FFY 2005 (based on FFY 2004 health status indicator data), they will be considered a 'conditional contractor' for one year. If positive change does not occur the following year, competitive proposal will be solicited for the identified jurisdiction.

Refer to Appendix E for a summary of the MCH contract model.

Section 2: Terms and Conditions *(Continued)*

P. Period of Contract

The MCH contract will be a one-year contract, from October 1, 2002 to September 30, 2003. Contractors will have the option of two additional renewal years, by mutual agreement between the Department and the Contractor, assuming satisfactory Contractor performance. In order to take advantage of the renewal option, the Contractor will have to prepare at a minimum, a two-year plan of work. The Contractor may choose to prepare a three or five year plan of work. The contracts will be prepared as one-year contracts.

Q. Amendments

During the contract year, no later than six months prior to the end of the contract, the contract may be amended. The Contractor may re-negotiate Performance Measure Targets and contract outcomes. The contractor may substitute short-term outcomes if the Department feels they are of equal value to the original outcomes. Acceptance of substitute outcomes is discretionary on the part of the Department. Anything re-negotiated will be handled with an amendment.

It is not acceptable to increase the short-term outcome for one health indicator and to decrease the short-term outcome for another indicator, simply because one is going well and the other is doing poorly.

R. Reporting Requirements

- 1.) Milestones:** Progress toward the planned milestones will be monitored by quarterly reports submitted to the Department. The reports will be a brief description of performance in achieving the milestones that were set for the quarter. Reports are due on the last day of the months of January, April, July and October. (See report forms/format in Appendix F)

Reporting elements that are required for milestones are a brief two-page description, as follows:

- a.) Progress toward achieving the milestones.
- b.) If milestones were not achieved, indicate the reasons and future plans to achieve the milestones.
- c.) Areas where milestones were exceeded.

The report format will, in two pages or less, report on completion of specified milestones or report progress toward achieving the milestones. For milestones that were not achieved, explain why, and what corrections are in place achieve the milestones. Describe favorable developments which enabled meeting the milestones sooner than anticipated or producing more beneficial results than originally anticipated.

The Contractor shall inform the Department of any significant delays, or adverse conditions, actual or anticipated, as soon as they become known if they will materially affect the milestones or cause the plan of work to fall behind schedule.

Section 2: Terms and Conditions *(Continued)*

2.) Financial Progress Report: Use of contract funds will be monitored by quarterly reports submitted to the Department. The reports, due on the last day of January, April, July and October, include the following reporting elements:

- a.) Enter on Line 1, the amount of funds invoiced to the Department during the reporting period.
- b.) Enter on Line 2, the amount of funds expended by the Contractor in meeting the contract outcomes.
- c.) Subtract the amount expended from the amount invoiced.
- d.) If the amount of funds expended by the Contractor in meeting the contract outcomes is greater than the amount invoiced, skip Line 4.
- e.) If the amount invoiced is greater than the amount expended, the contractor will indicate whether:
 - The remaining funds will be spent on meeting the outcomes in the MCH plan of work.
 - The difference was spent on other MCH issues as specified in part 6.9 of the contract Scope of Work.
 - The difference will be spent on other MCH issues as specified in part 6.9 of the contract Scope of Work.
- f.) The contractor's fiscal officer will sign the Quarterly Financial Progress Report, certifying the funds have been expended as specified by the terms and conditions of the contract.

3.) Short-term Outcomes: An annual performance report, due on October 30th following the end of the contract period, will report on the short-term outcomes as defined in the contract plan of work. For each short-term outcome the Contractor will describe the same areas as listed above.

The information in the reports will get at issues such as: What results were produced, why, and what's next? Were there any external factors or unanticipated effects, adverse or even beneficial, that had an impact on achieving the outcomes? Were barriers encountered? What got in the way? What tripped you up?

The report elements required for short-term outcomes shall, in no more than two pages, describe the progress of the plan of work for the contract period, and for each short-term outcome, describe the following:

- a.) Your progress toward achieving the outcome
- b.) If outcomes were not achieved, indicate the reasons and future plans to achieve the outcomes, and
- c.) Areas where short-term outcomes were exceeded.

S. Payments

The contract award amount will be disbursed in equal monthly payments, following the Department's receipt on an invoice from the Contractor. The Contractor shall use the Vendor Request For Payment (DH-38) standard invoice form/format for MCH billing (See example invoice in Appendix G).

Invoices submitted to the Department shall be uniquely identifiable invoices. Uniquely identifiable means the invoice can be distinguished by invoice number from a previously

Section 2: Terms and Conditions *(Continued)*

submitted invoice. The format for invoice numbers for the MCH contract is to be as follows: "MCH" to identify the program; two digits for the calendar year; and two digits for the month. (i.e.; the invoice number for the month of October 2002 would be entered as "MCH 02-10").

Monthly invoices are due on the last day of the month following each contract month. The final invoice is due to the Department on October 30th following the end of the contract period.

T. Use of Funds

Contract funds must be used to address MCH issues. The Contractor may subcontract funds for contract activities. Funds may not be used for cash payments to intended recipients of health services or for purchase of land, buildings or major medical equipment.

U. LPHAs as Medicaid Providers

No contract provisions preclude the Contractor from being a Medicaid provider. Contractors shall not use contract fund for services reimbursed under Medicaid.

V. On-Site Visits

During the contract year the MCH District staff will assess the Contractor's compliance with the terms of the contract and verify the Contractor's achievement of outcomes.

District staff will monitor to see that public health services encompassed by the contract are being addressed and that the agreed upon components of the multi-tiered service coordination system exist or are being established.

The focus of this contract is on consultation and technical assistance to assure the Contractor has the resources and expertise necessary to address targeted performance measures.

W. Contract Documentation Requirements

All contractors shall have documentation necessary to evaluate compliance with the terms of the contract. The documentation will provide the necessary evidence to ensure a complete history of your activities in order to determine contract compliance.

- 1.) Quarterly performance report forms for the reporting period being reviewed.
- 2.) Documentation to verify achievement of the short-term outcome specified in the MCH plan of work.
- 3.) Financial verification will focus on assurance that funds were expended for MCH issues.

X. Technical Assistance

The Department wants to maximize what can be delivered for the MCH dollars available by providing technical assistance. Education will be provided based on an assessment of the professional development needs of Contractors. The Department will consider other requests for appropriate technical assistance.

Section 2: Terms and Conditions (*Continued*)

Y. Calendar of Events

Event	Deadlines For FFY 2003 MCH Contract
Invitation for Proposals sent to Contractors.	04-01-02
Letter of Intent received by the Department – Central Office.	05-01-02
Proposal must be submitted to District Team for review. Appointments for final discussion meetings with Contractors may begin any time after receipt of IFP.	06-15-02
Negotiation of proposed plan of work with District Team must be completed.	07-31-02
Final plan of work received by the Department - Central Office.	08-01-02
Final contract awards sent to Contractor for signature.	08-15-02
Signed contract received by the Bureau of Family Health.	09-15-02
Contract begins.	10-01-02

The letter of Intent to Contract is to be received (by personal delivery, mail, or fax) by the Bureau of Family Health, by **3 p.m.** on the deadline date indicated.

The initial plan of work must be submitted to the MCH District Nurse Consultant to ensure adequate time is allowed for completion of negotiations.

The MCH Program Manager, in the Missouri Department of Health, Bureau of Family Health, shall receive the final copies of the plan of work, by **3 p.m.** on the deadline date indicated. The plan of work will be reviewed, and may be accepted or returned for clarification or changes. Contractors will be notified as soon as possible when their plan of work requires clarification or changes.

Final contract award packets will be mailed to the Contractor for signature by the date indicated in the table above. The signed contract (DH-70), along with the approved plan of work and scope of work, must be returned to the Department by the date indicated.

The contract period will be the federal fiscal year, October 1, 2002 through September 30, 2003.

Appendix A

Elements of FFY 2003 MCH Contract

Purpose: To establish an integrated multi-tiered service coordination system (direct, population-based, infrastructure) capable of adapting to address targeted maternal-child health issues.

MCH Service Coordination System:

Components of System	Related MCH Essential Services
Identification	2. Diagnose and investigate health problems and health hazards affecting women, children and youth. 10. Support research and demonstrations to gain new insights and innovative solutions to MCH problems.
Assessment	1. Assess and monitor maternal and child health status to identify and address problems.
Referral	4. Mobilize community partnerships between policymakers, health care providers, families, the general public, and others to identify and solve MCH problems. 7. Link women, children, and youth to health and other community and family services, and assure access to comprehensive, quality systems of care.
Assurance	8. Assure the capacity and competency of the public health and personal health workforce to effectively address MCH needs. 6. Promote and enforce legal requirements of the public health and personal health and safety of MCH population, and ensure accountability for their well being.
Education	3. Inform and educate the public and families, the general public, and others to identify and solve MCH problems.
Evaluation	9. Evaluate the effectiveness, accessibility, and quality of personal health and population-based MCH services. 5. Provide leadership for setting priorities, planning, and policy development to support community efforts to assure the health of MCH population.

Appendix B

Guidelines and Checklist for Preparing MCH Proposals

NOTE: Proposals are to be prepared using a font size of twelve (12).

Section One: Cover Page - Agency Information

Instructions: Complete the cover page of the proposal. This must be the first page of your proposal. The original copy of the proposal must have an original signature contain the following information:

1. Name of the agency or agencies involved
2. Contact person and the telephone number
3. Name of area(s) to be served
4. Authorized signature and date.

Section Two: Plan of Work

Instructions: Complete a separate plan of work for a minimum of two and a maximum of four Problem Priority Areas targeted for intervention in the FFY 2002 MCH contract. (See page 9 of the MCH Program Guidance, for selection criteria.) Be sure to address each category listed below.

In this contract 30% of the Contractor's efforts must be directed toward children with special health care needs. Efforts directed toward children with special health care needs must be identified in the plan of work with an asterisk.

A. Priority Problem Area and Statement of the Problem

Instructions: Enter the priority problem area to be addressed and describe the state of the problem in your jurisdiction.

B. Existing MCH system

Instructions: Describe the existing MCH system and the contractor's role in the existing system. You must describe the multi-tiered service coordination system and address each of the following components.

1. Identification
2. Assessment
3. Referral
4. Assurance
5. Education
6. Evaluation

C. Description of Target Population

Instructions: Define the numbers and characteristics of the target population you will assist. Indicate how they are different from the broader population of people in the community. In other words, whom are you targeting with your system?

Guidelines and Checklist for Preparing MCH Proposals (Continued)

D. Proposed MCH Service Coordination System

Instructions: Describe your proposed service coordination system. Indicate how this proposed system is different than your existing system, connects to your target population and how it contributes to the priority problem area described in the proposal. You must describe the MCH multi-tiered Service Coordination System and address each of the following components:

1. Identification
2. Assessment
3. Referral
4. Assurance
5. Education
6. Evaluation

E. Short-term Outcome and Negotiated Condition for Short-term Outcome = _____ %

Instruction: Specify the short-term outcome you are committed to achieving. Enter the negotiated condition for each short-term outcome. These outcomes state what behavior changes will occur for the target population – not what activities or processes you do – and should be stated in measurable terms. Indicate the timeline for anticipated achievement, and state how achievement of the short-term outcome will be verified. The short-term outcome must contribute to improving the MCH Performance Measures.

F. Milestones

Instruction: Specify in measurable terms the critical milestones to be achieved in progress toward your stated short-term outcome. Include the time line for achieving milestones.

G. Key Individuals

Instructions: Profile those individuals who will have the most responsibility for the project. Describe why they are the right people for the job. Focus on the energy, capacity and commitment they bring to the project. If a team approach to managing and/or implementing is used, specify how strengths of individuals are complementary and not duplicative.)

H. Community Partners

Instructions: Describe those organization, groups, and/or individuals in your community that you will work with, cooperate with, and/or collaborate with to achieve the short-term outcome. Indicate what they bring to the project that enhances or builds upon your agency capacity. Clearly articulate how they bring something additional, and are not duplicative.

Guidelines and Checklist for Preparing Proposals (Continued)

Section Three: Negotiated Priority Problem Areas

Instructions: If you believe a Priority Problem Area highlighted by the Department is adequately addressed in your community, you may choose an alternate Priority Problem Areas to address. However, for the a Priority Problem Area highlighted by the Department that has data which is worse than the State rate, you must describe the following: How the MCH multi-tiered Service Coordination System needs are being met, the agency or agencies that are addressing the Priority Problem Area, and the Contractor's involvement in the community's addressing of the Priority Problem. Provide supportive data and documentation to explain the reason for selecting an alternate or additional problem area. This applies to MCH problem areas highlighted by the Department that have the notation of "X" and "NA" under the column heading "County State Variance".

For highlighted MCH problem areas where the county/city baseline data are not statistically significant, the Contractor may request to target another problem area without having to provide supporting information. This applies only to Priority Problem Areas highlighted by the Department that have the notation of "N/S" under the column heading "County State Variance".

- A. For the Priority Problem Areas proposed as adequately addressed within the community complete the following information:
 - 1. Problem Priority Area
 - 2. Describe how the MCH multi-tiered Service Coordination System and system component needs are being met.
 - 3. Describe the agency or agencies in the community that are involved in addressing the Priority Problem Area.
 - 4. Describe the Contractor's involvement in the community's addressing of the Priority Problem.
- B. For each Alternate and/or Additional Problem Area to be considered for negotiation by the Contractor, complete the following:
 - 1. Provide supportive data and documentation to explain the reason for selecting alternate or additional problem area(s).
 - 2. Proceed by providing information as describe in Section Two steps A – H.

Instructions and Checklist for Submitting Proposals

Section One: For submission to the District Health Office for final review

- A. Assemble proposal sections for all problem priority areas
- B. Send completed proposal to your MCH District Nurse Consultant. (Preferred method e-mail)
- C. Submission Deadline: Proposals must be submitted to the MCH District Nurse Consultant by June 15, 2002 to ensure adequate time is allowed for completion of negotiations.

Section Two: For submission of Final Proposal Packet

- A. Assemble original copy of proposal. Proposal items are to be in the following order:
 - 1. Scope of Work *NOTE: Use the Scope of Work as printed in the MCH Program Guidance.*
 - 2. Cover Page – *Includes agency Information with authorized signature and date.*
 - 3. Proposal for each problem priority area
 - 4. Negotiated Priority Problem Areas (if applicable)
 - 5. Performance References Spreadsheet – *NOTE: Spreadsheet must be signed and dated by Contractor and District Team member.*
- B. Prepare four copies of completed proposal
- C. Send the original and four copies of completed proposal.
Faxed copies will not be accepted.
- D. Send complete proposal packet to:
MCH District Nurse Consultant
Missouri Department of Health and Senior Service
_____ District Health Office
- E. Submission Deadline to Department of Health and Senior Services – Central Office:
Must be received by 3 p.m., on August 1, 2002

Appendix C

FFY 2003 CONTRACT AMOUNTS

COUNTY / CITY	Contract Amount
Adair	\$ 20,213
Andrew	\$ 15,188
Atchison	\$ 12,621
Audrain	\$ 20,839
Barry	\$ 26,095
Barton	\$ 15,760
Bates	\$ 17,137
Benton	\$ 16,161
Bollinger	\$ 15,743
Boone	\$ 62,699
Buchanan	\$ 50,526
Butler	\$ 34,397
Caldwell	\$ 14,134
Callaway	\$ 23,612
Camden	\$ 21,648
Cape Girardeau	\$ 34,354
Carroll	\$ 14,376
Carter	\$ 13,758
Cass	\$ 35,320
Cedar	\$ 16,173
Chariton	\$ 13,702
Christian	\$ 25,571
Clark	\$ 13,446
Clay	\$ 36,399
Clinton	\$ 17,279
Cole	\$ 30,174
Cooper	\$ 15,539
Crawford	\$ 20,790
Dade	\$ 13,010
Dallas	\$ 17,451
Daviess	\$ 14,233
De Kalb	\$ 13,436
Dent	\$ 17,697
Douglas	\$ 16,216
Dunklin	\$ 32,860
Franklin	\$ 42,534
Gasconade	\$ 15,444
Gentry	\$ 13,135
Greene	\$ 32,579
Grundy	\$ 15,216

COUNTY / CITY	Contract Amount
Harrison	\$ 13,876
Henry	\$ 19,681
Hickory	\$ 13,029
Holt	\$ 12,498
Howard	\$ 14,068
Howell	\$ 30,023
Independence City	\$ 56,324
Iron	\$ 15,703
Jackson	\$ 67,892
Jasper	\$ 37,534
Jefferson	\$ 75,927
Johnson	\$ 30,065
Joplin City	\$ 35,382
Kansas City	\$ 252,573
Knox	\$ 12,068
Laclede	\$ 26,172
Lafayette	\$ 22,231
Lawrence	\$ 26,592
Lewis	\$ 14,088
Lincoln	\$ 24,218
Linn	\$ 16,422
Livingston	\$ 16,121
Macon	\$ 17,057
Madison	\$ 16,036
Maries	\$ 13,813
Marion	\$ 24,454
McDonald	\$ 21,770
Mercer	\$ 11,475
Miller	\$ 21,274
Mississippi	\$ 21,495
Moniteau	\$ 15,910
Monroe	\$ 13,796
Montgomery	\$ 15,147
Morgan	\$ 17,870
New Madrid	\$ 24,251
Newton	\$ 28,607
Nodaway	\$ 18,295
Oregon	\$ 15,561
Osage	\$ 13,623
Ozark	\$ 14,302

COUNTY / CITY	Contract Am Amount
Pemiscot	\$ 31,244
Perry	\$ 16,840
Pettis	\$ 28,190
Phelps	\$ 27,258
Pike	\$ 18,242
Platte	\$ 19,625
Polk	\$ 20,754
Pulaski	\$ 35,473
Putnam	\$ 12,460
Ralls	\$ 13,389
Randolph	\$ 22,292
Ray	\$ 18,962
Reynolds	\$ 13,754
Ripley	\$ 18,642
Saline	\$ 20,478
Schuyler	\$ 12,098
Scotland	\$ 12,419
Scott	\$ 33,624
Shannon	\$ 14,757
Shelby	\$ 13,351
Springfield	\$ 78,674
St. Charles	\$ 75,757
St. Clair	\$ 13,768
St. Francois	\$ 35,641
St. Louis City	\$ 293,092
St. Louis County	\$ 293,769
Ste. Genevieve	\$ 15,948
Stoddard	\$ 24,301
Stone	\$ 19,734
Sullivan	\$ 13,690
Taney	\$ 23,164
Texas	\$ 23,549
Vernon	\$ 20,256
Warren	\$ 18,371
Washington	\$ 24,626
Wayne	\$ 17,544
Webster	\$ 24,088
Worth	\$ 11,018
Wright	\$ 20,351

Appendix D

Division of Maternal, Child, and Family Health – Bureau of Family Health MCH Outcome Funding Plan

Year	Fund Category	Percent	Amount	Note:
FY01	% of Assured Funds % of Provisional Funds	= 100% = 0%	\$ 20,000	Current year. Cost reimbursement.
FY02	% of Assured Funds % of Provisional Funds Negotiated conditions for Provisional Funds: Example: Short-term Outcome #1 Short-term Outcome #2 Short-term Outcome #3 Short-term Outcome #4	= 100% = 0% = 5% = 15% = 20% = 60%	\$ 20,000 \$ 0 \$ 0 \$ 0 \$ 0 \$ 0	Negotiated conditions for Provisional Funds: - Though no funds will be assessed, LPHAs will negotiate an incentive condition for short-term outcomes.
FY03	% of Assured Funds % of Provisional Funds Negotiated conditions for Provisional Funds: Example: Short-term Outcome #1 Short-term Outcome #2 Short-term Outcome #3 Short-term Outcome #4	= 60% = 40% = 20% = 5% = 35% = 40%	\$ 12,000 \$ 8,000 \$ 1,600 \$ 400 \$ 2,800 \$ 3,200	Incentives for retaining Provisional Funds: - Based on negotiated conditions for short-term outcomes. - Payments are made based on Assured Funds and Provisional Funds. - If short-term outcomes are not met, then adjustments will be made from the final payment, or from the Assured Funds amount in the next year's contract award. Assess for placement on Conditional Contractor List. *
FY04	% of Assured Funds % of Provisional Funds Negotiated conditions for Provisional Funds: Example: Short-term Outcome #1 Short-term Outcome #2 Short-term Outcome #3 Short-term Outcome #4	= 50% = 50% = 10% = 15% = 30% = 45%	\$ 10,000 \$ 10,000 \$ 1,000 \$ 1,500 \$ 3,000 \$ 4,500	- Incentives continue as above. - Conditional Contractor List determinations continue.
FY05	% of Assured Funds Incentive Award added % of Provisional Funds <i>Conditions for short-term outcomes negotiated annually.</i>	= 40% = = 60%	\$ 8,000 \$ 4,000 \$ 12,000	Incentive Awards for Performance Measure Targets. ** Example: Note that incentive is added to the Assured Fund category. - Incentives to retain Provisional Funds continue as above. - Conditional Contractor List determinations continue.
FY06	% of Assured Funds % of Provisional Funds <i>Conditions for short-term outcomes negotiated annually.</i>	= 30% = 70%	\$ 6,000 \$ 14,000	- Continued monitoring of performance measures. - Incentives continue as above. - Conditional Contractor List determinations continue.
FY07	% of Assured Funds % of Provisional Funds <i>Conditions for short-term outcomes negotiated annually.</i>	= 20% = 80%	\$ 4,000 \$ 16,000	- Continued monitoring of performance measures. - Incentive continues as above. - Conditional Contractor List determinations continue.

*** Conditions for placement on the Conditional Contractor List:**

1. Did not meet 100% of short-term outcomes during the previous year, or did not submit 100% of reports and invoices by the contract deadline, or did not attend a District meeting to open the annual contract. ACTION:
 - a. Will remain a 'conditional contractor' for one year after placement on Conditional Contractor List.
 - b. During conditional year, if 100% of short-term outcomes are met, reports and invoices are submitted appropriately, and the Contractor attends a contract opening meeting, the Contractor's name will be removed from the Conditional Contractor List.
 - c. If no change in performance, other agencies will be considered as contractors for the county/city.
 - d. Competitive proposals will be solicited for the jurisdiction the following year. LPHA's may submit competitive bids.
2. No positive change in performance measure targets following initial three years (FY02-FY04), or in previous three years thereafter. ACTION:
 - a. Will remain a 'conditional contractor' for one year after placement on Conditional Contractor List.
 - b. Following conditional year, if performance targets show positive change, the Contractor will be re-instated as a viable contractor.
 - c. If no change in performance, competitive bids will be accepted the following year. LPHA's may submit competitive bids.

**** Determination of Incentive Award for Performance Measure Targets:**

1. Assess performance measure targets following the initial three years of new contract design.
2. Incentive Award based on percent of improvement for the county/city negotiated target set for identified performance measures.
3. Negotiated performance targets cannot have changed during the previous three years.
4. If targets have been re-negotiated, the Contractor is eligible for an Incentive Award three years later.
5. Performance measures have equal value.
6. The initial incentive pool is made up of:
 - a. Funds allocated to LPHAs/jurisdictions that did not participate in the FY03 and FY04 contracts and,
 - b. Contract funds accumulated through Provisional Funds in FY03 and FFY04.
7. A formula will determine the Incentive Award amount.
8. Incentive Awards cannot exceed the total amount in the Incentive Fund.
9. Incentive Awards will be allocated to Assured Funds for the following contract year.
10. In subsequent years, after FY 04, the incentive pool will be based on funds allocated to LPHAs/jurisdictions that did not participate in the previous year's contract and funds accumulated through Provisional Funds in the previous contract year only.

Appendix E

Core Elements of the MCH Contract:

Service Coordination	<u>Direct</u>: The coordination of needed services when working with an individual or family.* <u>Population-based</u>: The coordination functions performed to assure that preventive interventions and services are available for the entire MCH population of the jurisdiction.* <u>Infrastructure</u>: Activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health systems.* * This definition and service coordination system encompasses children with special health care needs.
Plan of Work	Contractor will develop a formal plan to address MCH population needs and the system components of service coordination. Using defined selection criteria, the plan of work must address 2, 3, or 4 problem priority areas identified on the MCH Performance Reference. DHSS will provide Contractors with MCH Performance References showing what particular MCH problem areas are targeted for intervention for each jurisdiction and will include target projections for future years. Problem areas may be addressed by other community funding sources. Additional MCH problem areas may be negotiated by the Contractor with introduction of supportive data/documentation. Target projections are negotiable during the initial writing of the plan of work. Elements of plan: - What the Contractor will do to address problem area(s) - Evidence-based interventions - Milestones and short-term outcomes for plan of work - A timeline for achieving each outcome - At a minimum, 30% of efforts must be directed toward children with special health care needs. - Deliverables: Negotiated short-term outcomes - Description of a population-based evaluation system which incorporates the MCH indicators
Negotiation Phase	Plan will be submitted to District staff for review and negotiation Negotiated plan submitted to DHSS
Reporting	Progress toward contract outcomes monitored by quarterly and annual reports submitted to DHSS
Payments	Award amount disbursed in 12 equal payments
Contract	Length of contract: One year with option of two additional renewal years First year: The Contractor will be assured to receive the full contract amount in FFY02, providing good faith efforts are documented Subsequent years: Beginning in FFY 2003, the MCH Outcome-funding Plan is implemented, and Contractor is accountable for negotiated outcomes Contract outcomes will be tracked by the program manager During the contract year the Contractor can substitute outcomes, if the DHSS determines they are of equal value to the original outcomes. Acceptance of substitute outcomes is discretionary on the part of the DHSS Funding: Non-competitive, based on current allocation formula and MCH Outcome Funding Plan
On-site visits	MCH District staff will monitor to see that public health services encompassed by the contract are being addressed and agreed upon components of multi-tiered service coordination system exist or are being established.
Technical Assistance	District meetings to discuss the contract design. Education will be provided on service coordination. Other appropriate technical assistance requests will be considered by the DHSS.

Appendix F

Reporting Forms/Format

FFY 2003 MCH Quarterly Report

Contractor: _____ Reporting Period: _____

Section One: Progress on Milestones

Instructions: Describe the progress in your work plan for the reporting period using the following format. For each milestone, describe: 1.) Your progress toward achieving the milestones, 2.) If milestones were not achieved, indicate the reasons and future plans to achieve the outcomes, and 3.) Areas where milestones were exceeded. Submit report to Department of Health and Senior Services, Bureau of Family Health, MCH Program Manager.

1.) Progress toward achieving the milestones.

2.) If milestones were not achieved, indicate the reasons and future plans to achieve the milestones.

3.) Areas where milestones were exceeded.

Appendix F Reporting Forms/Format (Continued)

FFY 2003 MCH Quarterly Report

Contractor: _____ Reporting Period: _____

Section Two: Quarterly Financial Progress Report

Instructions: Enter the MCH financial information for the reporting period. Enter summary totals only. Submission of detailed expenditure information is not required. Attach financial report to the quarterly report on milestones, and submit to Department of Health and Senior Services, Bureau of Family Health, MCH Program Manager.

Line 1 \$ _____ Enter the amount of funds invoiced to
DHSS during reporting period.

Line 2 \$ _____ Enter the amount of funds expended by contractor
in meeting the contract outcomes.

Line 3 \$ _____ Enter the difference between line 1 and line 2.

If difference is a positive amount, complete lines 4 and 5.

If difference is a negative amount, skip line 4 and complete line 5.

Line 4 *If line 3 is a positive amount, check all that apply below:*

☐

Funds will be spent on meeting the outcomes in the
MCH plan of work.

☐

Funds have been spent on other MCH issues as specified
in part 6.9 of the contract Scope of Work.

☐

Funds will be spent on other MCH issues as specified
in part 6.9 of the contract Scope of Work.

*NOTE: MCH contract funds must be expended during
the current contract year.*

I certify to the best of my knowledge and belief that this report is correct and complete and
that funds have been expended as specified by the terms and conditions of the contract.

Line 5 _____
Signature of Fiscal Officer

Date

Phone Number

Appendix F Reporting Forms/Format (Continued)

FFY 2003 MCH Year End Report
Progress on Short-term Outcomes

Contractor: _____ Report Prepared by: _____

Instructions: Describe below the progress in your work plan for the contract period. For each short-term outcome, describe the following: 1.) Your progress toward achieving the outcome, 2.) If outcomes were not achieved, indicate the reasons and future plans to achieve the outcomes, and 3.) Areas where short-term outcomes were exceeded. Submit to Department of Health and Senior Services, Bureau of Family Health, MCH Program Manager.

1. (Enter Short-term Outcome #1)

- a.) Progress toward achieving the short-term outcome.
- b.) If outcome was not achieved, indicate the reasons and future plans to achieve the outcome.
- c.) Areas where outcome was exceeded.

2. (Enter Short-term Outcome #2)

- a.) Progress toward achieving the short-term outcome.
- b.) If outcome was not achieved, indicate the reasons and future plans to achieve the outcome.
- c.) Areas where outcome was exceeded.

3. (Enter Short-term Outcome #3)

- a.) Progress toward achieving the short-term outcome.
- b.) If outcome was not achieved, indicate the reasons and future plans to achieve the outcome.
- c.) Areas where outcome was exceeded.

4. (Enter Short-term Outcome #4)

- a.) Progress toward achieving the short-term outcome.
- b.) If outcome was not achieved, indicate the reasons and future plans to achieve the outcome.
- c.) Areas where outcome was exceeded.

Appendix G



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
VENDOR REQUEST FOR PAYMENT

VENDOR USE																											
VENDOR NAME		INVOICE NUMBER																									
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COMMENTS																											
I CERTIFY THAT THIS REPORT IS TRUE AND THAT ALL PAYMENTS CLAIMED ARE IN ACCORDANCE WITH THE PROVISIONS SET FORTH IN THE CONTRACT.																											
AUTHORIZED SIGNATURE ▶		TITLE	DATE																								
FOR DHSS PROGRAM USE ONLY																											
PURCHASE ORDER (SC, SCS DOCUMENT NUMBER)		RECEIVER DOCUMENT (RC) NUMBER																									
PROGRAM / BUREAU APPROVAL SIGNATURE(S)		TITLE	DATE APPROVED																								
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Appendix H

Glossary

1. **Assured Funds:** The portion of the contract award amount that the Contractor is guaranteed to receive. The part that is NOT dependent on performance of contract requirements. (See Provisional Funds.)
2. **Children:** A child from birth (0) through the 21st year, who is not otherwise included in any other class of individuals.
3. **Children with special health care needs:** All children with chronic conditions who require more than routine health care. The federal Maternal and Child Health Bureau's (MCHB) definition is as follows: "Children with special health care needs are those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who require health and related services at a type or amount beyond that required by children generally."

This is not limited to those who would meet the Department of Health, Bureau of Special Health Care Needs program eligibility criteria.

Examples using the broad federal (MCHB) definition: Children who have or are suspected of having the following conditions:

- a. chronic otitis media
 - b. behavioral problems such as Attention Deficit Disorder (ADD)
 - c. learning disabilities
 - d. delayed speech development
 - e. age inappropriate height for weight
 - f. chronic infections
 - g. asthma
 - h. heart defects or conditions
 - i. scoliosis
 - j. diabetes
 - k. seizures
 - l. genetic conditions
 - m. other conditions which require health and related services at a type and amount beyond that required by children generally.
4. **Community Partners:** A person, in an agency or other entity outside your direct control, upon whom you rely for to build and sustain your service coordination system.
 5. **Conditional Contractor List:** The list of contractors that are considered to have provisional contractor status for one year based on specific identified contract performance items.
 6. **Deaths to Children Aged 1-14 Caused by Motor Vehicle Crashes:** Includes occupant, pedestrian, motorcycle, bicycle and related deaths caused by motor vehicles.
 7. **Inadequate Birth Spacing:** Live births occurring to females who had a prior live birth within eighteen months.

Appendix H Glossary (*Continued*)

8. **Inadequate Prenatal Care:** Fewer than five prenatal visits for pregnancies less than 37 weeks, fewer than eight visits for pregnancies 37 weeks or longer, or care beginning after the first four months of pregnancy.
9. **Incentive Award:** Additional funds a Contractor may receive based on positive change in Performance Measure Targets.
10. **Incentive Fund:** The pool of MCH funds, comprised of funds allocated for, but unused by a jurisdiction, and any prior year provisional funds withheld for non-performance of contract requirements.
11. **Infants:** Children under one year of age not included in any other class of individuals.
12. **Long-term Outcome:** Long term accomplishments to affect changes in population health status and/or the department's strategic objectives addressed by the contract. Improvement in the performance measure targets is the ultimate outcome.
13. **Medical home:** Primary health care that is: accessible, continuous, comprehensive, family centered, and coordinated and is directed by an appropriately trained and licensed health care professional.
14. **Milestone:** The critical steps that must be achieved to ensure that a project is on course to achieve the short-term outcomes.
15. **Obese Child:** A child whose weight is at or above the 95th percentile.
16. **Outcome:** Benefits for participants or public following performance of work in a contract.
17. **Outcome Measurement:** The assessment of the results of a program compared to its intended purpose.
18. **Performance Measure:** The specific item of information that tracks the contractor's success/effectiveness in completing the services described in the scope of work. A statement of a requirement that, when successfully addressed, will lead to an improved health status indicator and/or the department's strategic objectives addressed by the contract.
19. **Performance Measure Target:** The annual objective for improvement in a health status indicator.
20. **Pregnant Woman:** A female from the time she conceives to 60 days after birth, delivery, or expulsion of fetus
21. **Provisional Funds:** The non-assured portion of a Contractor's award amount that may be retained by the Contractor based on full performance of contract requirements.
22. **Preventive services:** Activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Appendix H Glossary (*Continued*)

23. **Service Coordination:** A collaborative process that addresses the health needs of a population through identification, assessment, referral, assurance, education and evaluation, using communications and available resources to promote quality and improved outcomes. The three tiers of MCH service coordination are:
 - a. Direct: The coordination of needed services when working within individual or family.
 - b. Population-based: The coordination functions performed to assure that preventive interventions and services are available for the entire MCH population of the jurisdiction.
 - c. Infrastructure: Activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health systems.
24. **Short-term Outcome:** For the MCH contract this means annual measures of change that make the system work better. The specific result that a contractor will commit to achieve within the contract period. Attainment can be verified through documentation provided by the contractor at the end of the contract year.
25. **Supplanting:** Utilizing funds from this contract to fund activities that are currently being funded from another source. However, the funding from this contract may be used to increase or expand activities funded by other sources.
26. **System:** A perceived whole whose elements “hang together” because they continually affect each other over time and operate toward a common purpose.
27. **Target Population/Program Participant:** Are people or entities that directly interact with an organization's interventions and service coordination system. This interaction is intended to result in a change in the participants' behavior or condition in line with short-term outcomes and mission.
28. **Uninsured:** Children without public or private insurance policies.
28. **Verification:** Establishing that something represented to happen does in fact take place. Verification typically focuses on milestone and short-term outcome accomplishments.

Appendix I

Best Practices to Meet Performance Measures

Guidelines for Selecting Evidence Based Practice Interventions From the Literature

The basic questions to ask when reviewing an article include: 1.) Are the study results valid?; 2.) What are the results?; 3.) Will the results help in improving the health status of the clients/communities (this includes a fit with your community culture)?; and 4.) Is the evidence strong enough to influence policy?

In reviewing the literature a systematic approach should be followed to review, analyze, and select information or "evidence" in support of public health interventions. This document is a general guide for this process and is not intended to be all-inclusive. Ideally, evaluating the literature for the evidence based practices would involve a minimum of two readers reviewing the material with different tools and then comparing the results to determine what can be labeled a so-called "best practice". This is not always possible. The following guidelines are offered to assist you in your own review of information available to make determinations about what might be considered a "best public health practice" Much of this work is based on the work of the Minnesota Department of Health, the Division of Community Health, Section of Public Health Nursing.

For each article or other piece of information to be reviewed, select the related criteria that fit with the type of material you are reviewing. Remember to ask questions about the data such as: What is the data source used in this study? Who provided the data? If rates and ratios are used, has the proper conversion of rates to number and numbers to rates been presented? What is the geographic level of the data (household, district, and state)? What is the source of the population at risk? Is the information reliable? How was the numerator and denominator derived? This applies to articles and other materials on community, system, individual and family interventions. Well-designed studies can be poorly implemented and well-implemented programs can be poorly evaluated. Often knowledge of what does not work can also be of value. The literature should be reviewed carefully. Remember, it is not necessarily so because it is in print. Always question credibility, utility and generalizability.

Quality of evidence criteria for qualitative studies

Qualitative designs are used to focus on understanding and meaning of a public health system, program, or intervention. The goal is to understand and not necessarily predict. The researcher usually develops a model of what occurred in the social setting.

- There is a clear statement of the research question that indicates the study's purpose or aim. This statement is supported by foundational information. The research question if answered has practical applications that are useful for your situation.
- A "state of the art" literature is included in which conclusions or assertions are based on multiple references from professionally recognized sources that include references from refereed publications.
- The methodology is described and is appropriate for the study of the phenomena under investigation. There is a rationale for the methodology. The methodology employs multiple methods that are appropriate to the strategy (such as key informant interviews and focus groups).
- The research setting is appropriate and sample size is comprised of "information rich" cases that supply the data needed to understand the phenomena under investigation.
- Data are appropriate to the theoretical approach of the study and sufficient data have been collected to satisfy saturation with variation accounted for and explained.

Guidelines for Selecting

Evidence Based Practice Interventions From the Literature *(Continued)*

- The audit trail is detailed enough for the reader to reconstruct the process by which investigators reached their conclusion
- Accuracy and validity are accomplished by checking back with study informant's and/ or established through consensus of a second researcher coding the data.
- Potential bias of researcher is discussed.
- There is a description of how information was used and to whom it was reported.

Quality of evidence criteria for quantitative studies that are experimental or quasi-experimental designs

Experimental designs allow for the researcher to both manipulate the study factor and randomly assign participants to the intervention. Quasi-experimental designs allow for the researcher to manipulate the study factor but not randomization of participants. These designs are often used in program evaluation. Comparison groups or repeated measures are often used in these studies.

- There is a statement of the public health problem, community need or theory that includes the rationale for the selection to allow for replication.
- The intervention/variable is described and includes rationale for selection.
- The sampling technique is described and includes a description of randomization process or comparison group.
- The sample is representative of the population to which the study is generalized.
- There is a comparison or control group with adequate sample size, and the use of appropriate statistical analysis.
- The expected results or changes (outcome construct) related to implementing the intervention is clearly described.
- Outcome measures are clearly described, fit the outcome construct, and are appropriate for use in the practice setting.
- To increase external validity the study should be applicable to other settings, consistent with result of others studies and the data should be recent.
- Criteria for inferring casualty include a strong association between the dependent and independent variable (large effect size more important than statistically significant, in epidemiological studies the magnitude of the ratio of incidence rates is significant).

Quality of evidence criteria for quantitative studies that are non-experimental observational designs

Non-experimental studies generate knowledge about etiology and natural history of phenomena and look at the associations among variables but cannot prove causality.

These include analytic studies concerned with the determinants of problems and reasons for their distribution in a population, as well as descriptive studies that are concerned with describing the amount and distribution of a problem within a population. Examples are shortitudinal studies; repeated measures over time, case-control studies that compare two

Guidelines for Selecting

Evidence Based Practice Interventions From the Literature *(Continued)*

groups at one point in time and ecologic studies that assess the correlation between rates of exposure to the intervention and rates of change among different groups of populations.

- There is a comparison or control group
- Study size is sufficient for effect size and statistical methods are appropriate to type of analysis.
- Control was established for potential bias.
- Sample is representative to population.
- Study is applicable to other settings.
- Data is recent.
- Study question is relevant.
- Results are consistent with other similar studies.
- The expected change relationship is stated in clearly understandable.
- Measures are clearly discussed, understandable, and appropriate for the practice setting.
- The apparent cause precedes the effect in time.
- The likelihood of association between variables makes "common sense". Evidence from other experimental designs is supportive.
- The intensity of the intervention introduced and the length of time required before effect is noted is consistent.
- The relationship between variables is repeated in different populations under different circumstances among variables specified.
- There is no conflict with scientific knowledge of the phenomenon related to the likelihood of an association between the variables.
- The likelihood that an association between variables is causal is supported by causality known to exist in similar phenomenon.

Quality of evidence for criteria for expert opinion

Expert opinion is subjective. Analysis of expert opinion is also subjective and caution should be noted that agreement or disagreement with the philosophy of the author might influence your analysis. One way to determine the plausibility of the author is to note in the related professional literature how often the author is referenced.

- The expert's inquiry is carried out with a systematic approach and based on previous research.
- The expert's thesis is probable and strongly supported.
- The expert frequently substantiates opinions with evidence from credible sources and addresses limitations of evidence.
- There is a discussion of corroborating and opposing material from other experts in the discipline.
- The discussion is clear, strongly persuasive and compelling.

Guidelines for Selecting

Evidence Based Practice Interventions From the Literature *(Continued)*

In order for an intervention or program to be considered as a possible "best practice" that is evidenced based, the majority of the above criteria, as applied to the appropriate type of study or expert opinion, should be met. Once an evidenced based intervention is chosen, a plan should be developed to evaluate the results of the program that includes on-going continuous quality improvement.

References:

Minnesota Department of Health, the Division of Community Health (1999). Services. Tools for Analyzing Evidence in Support of Public Health Practice, 3rd edition.

Dever, G.E. (1997). Improving Outcomes in Public Health Practice: Strategy and Practice. Gaithersburg, MD: Aspen Publishers, Inc.

Increase the percent of infants born to pregnant women receiving prenatal care beginning in the first trimester

First trimester entry into prenatal care for an initial screening and risk assessment is critical to preventing many problems in the developing fetus and promoting the health of the mother. Nearly 80% of the women who are high risk for delivering a low birth weight baby can be identified on the first prenatal visit. Barriers to early entry into prenatal care may be associated with unplanned pregnancy, low socioeconomic status, unreliable transportation or lack of childcare.

Systems Development:

- Work with the community of interest to identify potential barriers to prenatal care. Function as active and integral participant in the identification of special populations at risk.
- Establish community health status baseline levels against which to set targets and measure achievement of quality benchmarks.
- Conduct public education programs about the importance of first trimester care targeting the communities at highest risk for late entry into prenatal care.
- Develop and disseminate standardized education information for community leaders, parents, teachers, community members, churches and civic groups regarding the importance of early prenatal care.
- Disseminate results of research and demonstration projects
- Ensure that education materials are culturally/linguistically appropriate. Collaborate with ethnic groups and community based organization, and private providers to address training needs with respect to cultural competency and culture-specific health problems.
- Convene meeting of local providers to identify locally or agency-specific strategies for identifying and serving at risk clients.
- Monitor health status of community to identify geographic and economic regions that have the lowest rates of first trimester care.
- Provide leadership to and develop capacity of community organizations to obtain information on the local populations perceptions of health problems and health needs.
- Convene meeting of local providers to identify locally or agency-specific strategies for identifying and serving at risk clients.
- Establish local partnership mechanisms involving, consumers, private providers and public agencies to address needs identified.
- Collaborate with ethnic groups and community based organizations and private providers to address the training needs with respect to cultural competency and culture-specific health problem.
- Partner with others to conduct public health campaigns regarding the importance of prenatal care. Target communities at highest risk.
- Work with the faith community to assist racial and ethnic minority women in learning about the availability of early prenatal care resources and the importance of early prenatal care.
- Work with others to identify culturally, linguistically, economically or geographically isolated individuals/families and link to resources.

Increase the percent of infants born to pregnant women receiving prenatal care beginning in the first trimester *(Continued)*

- Participate on advisory committees in state/local agencies related to entry into prenatal care.
- Monitor and evaluate initiatives to address entry into prenatal care on continuing basis initiatives.
- Assure low-cost comprehensive family planning services designed to meet the cultural, and age needs of the client.
- Provide outreach services (including home visiting) particularly to uninsured and other hard to reach populations.
- Develop and disseminate community resource directories. Collaborate with agencies and private companies working to develop such materials on an ongoing basis. Ensure translation of resource directories into other languages.

References and Best Practices:

- Bauer, P. (1998). Recipient and provider perspectives to rural prenatal care. *Journal of Community Health Nursing*, 15 (4), 237-249.
- Henderson, J. (1994). The cost effectiveness of prenatal care. *Health Care Financing Review*, 15 (4), 21-31.
- Stout, A.(1997). Prenatal care for low-income women and the health belief model: A new beginning. *Journal of Community Health Nursing*, 14(3), 169-180.
- Mahon, J. McFarlane, J., &Golden, K. (1991) De madres a madres: A community partnership for health. *Public Health Nursing*, 8(1), 15-19.
- The David and Lucile Packard Foundation, *The Role of Prenatal Care in Preventing Low Birth Weight*, Volume 5, No. 1, Spring 1995. See www.futureofchildren.org
- The National Institute of Health, National Institute of Nursing Research, *Community-Based Health Care: Nursing Strategies* www.nih.gov/ninr/research/vol7
- Knowledge Path: Infant Mortality (June 2000) [www. ncemch.org/RefDes/infmortKP.html](http://www.ncemch.org/RefDes/infmortKP.html)

Strategies:

- Improve early and regular participation in prenatal care
 - Identify pregnancy early and refer for prenatal care.
 - Work with other resources in area to develop comprehensive referral for pregnant women.
 - Provide professional education about prenatal care to health care providers.
 - Provide TEMP and MC+ for Kids enrollment.
 - Provide referral and follow-up to WIC and other services.
- Assess current rates of early and regular participation in prenatal care
 - Compile data by age, race, marital status, geographic location, health care coverage, and type of provider.
 - Develop a plan to target outreach efforts based on data analysis.

Increase the percent of infants born to pregnant women receiving prenatal care beginning in the first trimester *(Continued)*

- Collaborate with inter-agency groups to share resources and information, and to aid in identifying and providing outreach to pregnant women.
- Modify health services to better meet the needs of pregnant and parenting teens.
 - Coordinate between agencies and providers to enhance early diagnosis and referral.
 - Encourage staff comfort and knowledge about pregnant adolescents.
 - Assure client needs for service coordination are met including plans for education, family planning, medical care, support groups, individual counselors and social services.
 - Collaborate with schools and juvenile authorities to provide programs, which focus on family planning and appropriate prenatal care.
 - Providing life skills education (targeting the high school audience).

Decrease the percent of women with inadequate prenatal care

According to Healthy People 2010, women with an unintended pregnancy are less likely to seek prenatal care in the first trimester and more likely not to obtain prenatal care at all. She is less likely to breastfeed and more likely to expose the fetus to harmful substances such as tobacco or alcohol.

Providing outreach, education and clinical services to hard-to-reach and/or vulnerable populations such as women who are disabled, homeless, or abuse substances is difficult and necessary.

Systems Development:

- Monitor health status of community to identify geographic and economic regions that have the lowest rates of first trimester care.
- Provide leadership to and develop capacity of community organizations to obtain information on the local populations perceptions of health problems and health needs.
- Convene meeting of local providers to identify locally or agency-specific strategies for identifying and serving at risk clients.
- Establish local partnership mechanisms involving, consumers, private providers and public agencies to address needs identified.
- Collaborate with ethnic groups and community based organizations and private providers to address the training needs with respect to cultural competency and culture-specific health problem.
- Partner with others to conduct public health campaigns regarding the importance of prenatal care. Target communities at highest risk.
- Work with the faith community to assist racial and ethnic minority women in learning about the availability of early prenatal care resources and the importance of early prenatal care.
- Work with others to identify culturally, linguistically, economically or geographically isolated individuals/families and link to resources.
- Participate on advisory committees in state/local agencies related to entry into prenatal care.

Best Practices:

- National Institute of Health, National Institute of Nursing Research, Community-Based Health Care: Nursing Strategies: www.nih.gov/ninr/research/vol7
- Knowledge Path: Infant Mortality (June 2000). ledge Path: Infant Mortality (June 2000) National Center for the Education of Maternal and Child Health www.ncemch.org/RefDes/infmortKP.html
- da Silva, O. (1998). Prevention of Low Birth Weight/Preterm Birth. www.ctfphc.org

Decrease the percent of women who have reported smoking during pregnancy.

Smoking during pregnancy is the most preventable cause of poor pregnancy outcomes in the United States. Various effects of cigarette smoking on pregnancy have been studied. They include placental changes, pregnancy complications and perinatal loss. National data suggests that, in a given visit with a clinician, most smokers are not advised to quit smoking and are not assisted with cessation.

Systems Development:

- Monitor health status of community to identify geographic and economic regions that have the highest rates of smoking in women of childbearing age.
- Provide leadership to and develop capacity of community organizations to obtain information on the local populations perceptions of the health consequences associated with smoking during pregnancy.
- Function as active and integral participant in the identification of special populations at risk.
- Establish community health status baseline levels against which to set targets and measure achievement of quality benchmarks.
- Conduct public education programs about the health consequences of smoking during pregnancy targeting the communities at highest risk for smoking and pregnancy.
- Develop and disseminate standardized education information for community leaders, parents, teachers, community members, churches and civic groups regarding smoking.
- Disseminate results of research and demonstration projects to the community and health care providers.
- Ensure that education materials are culturally/linguistically appropriate. Collaborate with ethnic groups and community based organization, and private providers to address training needs with respect to cultural competency and culture-specific health problems.
- Convene meeting of local providers to identify locally or agency-specific strategies for identifying and serving at risk clients.
- Collaborate with ethnic groups and community based organizations and private providers to address the training needs with respect to cultural competency and culture-specific health problem.
- Work with the faith community to assist racial and ethnic minority women in learning about the availability of smoking cessation resources.
- Work with others to identify culturally, linguistically, economically or geographically isolated individuals and link to resources.
- Monitor and evaluate on a continuing basis.
- Provide outreach services particularly to uninsured and other hard to reach populations.
- Develop and disseminate community resource directories. Collaborate with agencies and private companies working to develop such materials on an ongoing basis. Ensure translation of resource directories into other languages.

Decrease the percent of women who have reported smoking during pregnancy.
(Continued)

Best Practices and References:

- The Guide to Community Preventative Services (The Community Guide) provides decision makers with recommendations regarding population-based interventions to promote health and to prevent disease, injury, disability and premature death, appropriate for use by communities and health care systems. (For more information about the Community Guide, including links to a variety of resources, go to www.thecommunityguide.org. The Tobacco Use Prevention chapter summarizes the published evidence on effectiveness of interventions to prevent product use initiation, to increase tobacco use cessation, and to reduce exposure to environmental tobacco smoke. To review the Tobacco Use Prevention Chapter on line go to www.cdc.gov/mmwr/preview/mmwrhtml/rr4912a1.htm
- MMWR 2000 49:RR-12: Strategies for Reducing Exposure to Environmental Tobacco Smoke, Increasing Tobacco-Use Cessation, and Reducing Initiation in Communities and Health Care Systems. www.cdc.gov/mmwr/preview/mmwrhtml/rr4912a1.htm
- ACHRP recommendations for clinicians: ACHRP recommendations for clinicians: www.ahcpr.gov/reseach/apr96/dept8.htm
- American Legacy Foundation: Fighting for a Tobacco Free Future. This web site offers fact sheets and information on tobacco, tobacco use, and tobacco prevention activities. www.americanlegacy.org/indexw.html
- Campaign for Tobacco-Free Kids. National Center for Tobacco-Free Kids, 1400 Eye Street, Suite 1200, Washington, D.C. 20005 www.tobaccofreekids.org/
- American Lung Association – Tobacco control – Tobacco Control Index. www.lungusa.org/tobacco/tobacco_control_index.html
- Smoke-Free Families: Innovations to Stop Smoking During and Beyond Pregnancy. Smoke-Free Families is a national program of the Robert Wood Johnson Foundation. This web site offers information for prenatal care providers, for pregnant smokers, for organizations, and information on what is new in research. www.smokefreefamilies.org/
- Join Together Online. This web site offers brief summaries of current journal articles and information on a topics of alcohol, tobacco and other drugs and the impact on pregnancy. www.jointogether.org
- AHCPR recommendations for smokers who want to quit: www.ahcpr.gov/clinic/toolkit.htm
- Assessment, Planning, and Policy Support Resources:
 - *School Health Advisory Council Guide*. Developed by the Missouri Coordinated School Health Coalition to assist school personnel with convening an interdisciplinary group to address school health issues. Includes suggestions and tools for membership, and an assessment tool for each component of the Coordinated School Health Model. To obtain a copy contact the Missouri Department of Health and Senior Services, Bureau of Health Promotion, 573/522-2820.
 - *School Health Index For Physical Activity and Health Eating: A Self-Assessment and Planning Guide*. February 2000. Centers for Disease Control and Prevention (CDC), Division of Adolescent and School Health (DASH). A *SHI* is available for elementary and secondary schools free of charge through the following options: Download from CDC website: www.cdc.gov/nccdphp/dash; Request by e-mail: ccdinfo@cdc.gov; Call the DASH Resource Room: 770/488-3168; or request by toll-free fax: 1-888/282-7681.

Decrease the percent of women who have reported smoking during pregnancy.

(Continued)

- *Making The Grade: A Guide to School Drug Prevention Programs* (Updated). 1999. Thorough review of K-12 alcohol, tobacco and other drug use prevention curricula, and comprehensive health curricula. Drug Strategies, 12575 Eye Street, NW, Suite 210, Washington, DC 20005. 202/289-9070. \$14.95+\$3.00 shipping and handling. www.drugstrategies.org
- *Choosing the Tools: A Review of Selected K-12 Health Education Curricula*. 1995. Education Development Center, Inc. 55 Chapel St., Newton, MA 02158-1060. \$19.95+\$5.95. shipping and handling. Order online at www.edc.org
- *Fit, Health, and Ready to Learn Part I: Physical Activity, Health Eating, and Tobacco-Use Prevention – A School Health Policy Guide*. 2000. National Association of State Boards of Education (NASBE). 277 South Washington Street, Suite 100, Alexandria, VA 22314, 1-800/220-5183. \$22.00 plus \$4.00 shipping and handling.
- Evidenced-Based Tobacco Use Interventions identified by the Centers for Disease Control and Prevention, Division of Adolescent and School Health - Programs That Work. The Programs That Work are identified as examples of programs that have been proven effective in reducing tobacco use. Curriculum fact sheets, evaluation fact sheets and ordering information for the following curricula be viewed at www.cdc.gov/nccdphp/dash/rct/tob-curric.htm
 - *Project Toward No Tobacco Use* (Project TNT) – (A tobacco use prevention-specific curriculum.) A social influences plus physical consequences curriculum for 6th to 8th grade students taught in ten core lessons and two booster lessons of 40-50 minutes each. The two booster lessons are taught one year after the core lessons. Results: Reduced initiation of cigarette smoking by approximately 26%, reduced initiation of smokeless tobacco use by approximately 60%, reduced weekly or more frequent cigarette smoking by approximately 30%, and eliminated weekly or more frequent smokeless tobacco use. Duration of behavior changes: Two years. Contact: ETR Associates, PO Box 1830, Santa Cruz, CA 69061-9979. 800/321-4407. www.etr.org
 - *Life Skills Training* (Middle School) – (An alcohol, tobacco, and other drug use prevention curricula that effectively reduced tobacco use.) A personal and social skills curriculum for middle school students (Grades 6-8) delivered in 15 sessions the first year, 10 sessions the second year, and eight sessions the third year. Results: In 10 separate studies, tobacco, alcohol, and marijuana use were reduced at seventh grade 50% to 75%. Results eroded only slightly by the end of high school with 44% fewer students using all three substances one or more times per month and 66% fewer students using all three substances one or more times per week. Duration of behavioral changes: Six years. Contract: Princeton Health Press, 115 Wall Street, Princeton, NJ 08540. 800/636-3415. www.lifeskillstraining.com
- Identified as “Exemplary Programs” that reduced tobacco use among school-age youth by the U.S. Department of Education’s Expert Panel
 - *Project Northland* – A social resistance skills curriculum focusing on prevention of alcohol use delivered in eight sessions per year in grades six through eight. Results: Reduced tobacco and alcohol use 27%, reduced tobacco use alone 37%, and reduced marijuana use 50%. Duration of behavioral changes: Three years. Contact: Hazelden Publishing and Education, PO Box 1276, Center City, MN 55012-0176. 800/328-900 Ext. 4030. www.hazelden.org

Decrease the percent of women who have reported smoking during pregnancy.

(Continued)

- *Project Alert* – A social resistance skills curriculum for students in grades six and seven, or seven and eight, taught in 11 sessions the first year and three sessions the second year. Results: Reduced drinking by 50%, reduced marijuana use 33% to 60% in eighth grade, and reduced tobacco use 17% to 55% in eighth grade. Also resulted in significant effects on attitudes and some effects on beliefs about harm of drugs and perceived norms of drug use. Duration of behavioral changes: 15 months. A six-year follow-up evaluation was completed. Contact: Best Foundation, 725 S. Figueroa Street, Suite 1615, Los Angeles, CA 90017. 800/253-7810. www.projectalert.best.org

Identified as “Promising Programs” that reduced tobacco use among school-age youth by the U.S. Department of Education’s Expert Panel

- *Growing Healthy* – A comprehensive health education curriculum that teaches health information and personal and social skills through 40 or more sessions per year in grades K-6. Results: Reduced tobacco use 29% by ninth grade and significantly affected knowledge and attitudes about health. Duration of behavioral changes: Two years. Contact: National Center for Health Education, 72 Spring Street, Suite 208, New York, NY 10012. 800/551-3488. www.nche.org
- *Teenage Health Teaching Modules* – A comprehensive health education curriculum taught in 40-70 sessions per year for students in grades 7-12. Social resistance skills are covered through broader personal and social skills instruction. Results: Moderate reductions in alcohol, tobacco, and other drug use of senior high school students. Also produced a significant effect on knowledge and attitudes about health for both junior and senior high school students. Duration of behavioral changes: Immediate post-test. No follow-up evaluation has been completed. Contact: Educational Development Center, 55 Chapel Street, Newton, MA 02158-1060. 800/225-4276. www.edc.org/thtm
- *Minnesota Smoking Prevention Program* – A social influence approach with a peer leader component. Includes normative education, analyzing advertising pressures and refusal skills. Six sessions for any of grades 6-10; no follow-up lessons. Duration of behavioral change: Six years where school-based program was part of community-wide intervention also focusing on diet and exercise. Contact: Hazelden Information and Educational Services, PO Box 176, Center City, MN 55012. 800/328-9000 Ext 4030. www.hazelden.org

Identified as having reduced tobacco use according to studies:

- *Know Your Body* – A comprehensive health education curriculum covering personal and social skills through approximately 60 sessions per year in grades K-6. Results: Reduced tobacco use 73% in ninth grade (greater reductions in use for males) and increased health knowledge (including cigarette and drug information) for nine years. Duration of behavioral changes: Six years. Contact: American Health Foundation, 675 Third Avenue, 11th Floor, New York, NY 10017. 212/551-2507. www.ahf.org
- *Life Skills Training* (Grades 3-5) – A new version of the Life Skills Training curriculum for students in grades 3-5 also focuses on combining information with social skill development as a means of preventing initiation of tobacco and other drugs. The program consists of 24 lessons taught over three years, eight each year. Result of an initial research study found that elementary students who participate in the program smoked cigarettes 63% less than students in control schools (6). Contact: Princeton Health Press, 115 Wall Street, Princeton, NJ 08540. 800/636-3415. www.lifeskillstraining.com

Decrease the percent of women who have reported smoking during pregnancy.

(Continued)

- Campaign for Tobacco Free Kids: www.tobaccofreekids.org
- Konopka Institute for Best Practices in Adolescent Health at the University of Minnesota, University Gateway, 200 Oak St. SE Suite 260, Minneapolis, MN 55455. The institute focuses on some of the major threats to young people: violence, tobacco, alcohol and teen pregnancy. www.konopka.umn.edu
- *Fit, Health, and Ready to Learn Part I: Physical Activity, Health Eating, and Tobacco-Use Prevention – A School Health Policy Guide*. 2000. National Association of State Boards of Education (NASBE). 277 South Washington Street, Suite 100, Alexandria, VA 22314, 1-800/220-5183. \$22.00 plus \$4.00 shipping and handling.
- *Health Policy Coach*. Provides tools and strategies for policy development in the eight components of Coordinated School Health, and in tobacco use prevention, physical activity, and health eating. Available only from the California Center for Health Improvement at www.healthpolicycoach.org

Strategies:

- Implement smoking as a fifth vital sign, which would assure assessment of the smoking status of every woman at each preconceptional, prenatal and post-natal visit.
- Implement smoking cessation interventions that ASK, ASSESS, ADVISE, ASSIST, and ARRANGE follow-up for pregnant clients who smoke.
 - Coordinate with other programs to present a consistent message
- Establish baselines
 - Compile birth certificate data for smoking rates of pregnant women
 - Establish a consistent health risk assessment form
 - Conduct clinical/physician audits
- Conduct Public Education
 - Service Coordination
 - Provide culturally competent literature and education in frequented places
 - Create and integrate school, community and media programs
 - Conduct counter-advertising
 - Encourage work sites, schools, communities, and others to examine their policies about tobacco.
- Conduct Professional Education
 - Obtain approved training in smoking cessation to maintain current knowledge base
 - Promote positive peer influence in the professional and public arenas
 - Mass mailings
 - Speakers
 - Exhibits
- Execute existing systematic smoking cessation interventions
 - Assure access to smoking cessation programs:
 - March of Dimes
 - American Lung Association
 - Clinical Practice Guideline on Smoking Cessation
 - Encourage use of vouchers or discount on class registration fee

Decrease the percent of mothers with live births, which occurred within 18 months of a previous live birth.

According to Healthy People 2010, encouraging females of all ages to space their pregnancies adequately can help lower the risk of adverse prenatal outcomes including low birth weight, preterm birth, and small for gestational age. To the extent that very closely spaced pregnancies are unplanned, unintended pregnancy may increase the risk of low birth weight. Health care providers can help all new mothers understand that they can become pregnant soon after delivery and should assist them with contraceptive education.

Family planning remains a keystone in attaining a national goal aimed at achieving planned, wanted pregnancies and preventing unintended pregnancies. Family planning services provide opportunities for individuals to receive medical advice and assistance in controlling if and when they get pregnant and for health providers to offer health education and related medical care. (Healthy People 2010)

Half of all pregnancies in the United States are unintended; that is, at the time of conception the pregnancy was not planned or wanted. The rates of unintended pregnancy remain highest among teenagers, women aged 40 years or older, and low-income African-American women. In 1997, nearly one in five births to teens moms was a birth of a second order or higher.

Systems Development:

- Monitor health status of community to identify geographic and economic regions that have the lowest rates of first trimester care and late entry into prenatal care.
- Provide leadership to and develop capacity of community organizations to obtain information on the local populations perceptions of health problems and health needs related to birth spacing, access to family planning resources, and prenatal care.
- Work with the community of interest to identify potential barriers to family planning and prenatal care. Function as active and integral participant in the identification of special populations at risk. (For example women who may be homeless, handicapped, undocumented aliens, abuse substances, or lack health insurance). Assure services are available.
- Establish community health status baseline levels against which to set targets and measure achievement of quality benchmarks.
- Conduct public education programs about the importance of first trimester care, birth spacing, and family planning targeting the communities at highest risk for late entry into prenatal care.
- Develop and disseminate standardized education information for community leaders, parents, teachers, community members, churches and civic groups regarding the importance of early prenatal care, family planning and birth spacing.
- Ensure that education materials are culturally/linguistically appropriate. Collaborate with ethnic groups and community based organization, and private providers to address training needs with respect to cultural competency and culture-specific health problems.
- Convene meeting of local providers to identify locally or agency-specific strategies for identifying and serving at risk clients.

Decrease the percent of mothers with live births, which occurred within 18 months of a previous live birth. *(Continued)*

- Collaborate with ethnic groups and community based organizations and private providers to address the training needs with respect to cultural competency and culture-specific health problem.
- Work with the faith community to assist racial and ethnic minority women in learning about the availability of family planning resources.
- Work with others to identify culturally, linguistically, economically or geographically isolated individuals/families and link to family planning resources.
- Participate on advisory committees in state/local agencies related to family planning.

Best Practices and References:

- Knowledge Path: Infant Mortality (June 2000) National Center for the Education of Maternal and Child Health www.ncemch.org/RefDes/infmortKP.html
- The guide to Community Preventative Services (The Community Guide) will summarize the published evidence on effectiveness of populations-based interventions that have been used in communities to prevent HIV, STD, and unintended pregnancy. Anticipated date of publication: winter 2002. The guide to Community Preventative Services (The Community Guide) will summarize the published evidence on effectiveness of populations-based interventions that have been used in communities to prevent HIV, STD, and unintended pregnancy. Anticipated date of publication: fall 2002. www.thecommunityguide.org
- Promoting Optimal Prenatal Care for Healthy Birth Outcomes (September 2000), Oregon Health Division, Center for Child and Family Health. www.ohd.hr.state.or.us/ccfh/pren.pdf.
- The Best Intentions: Unintended Pregnancy and the Wellbeing of Children and Families. 1995, Washington, D.C., National Academy Press.
- Henderson, J. (1994). The cost effectiveness of prenatal care. *Health Care Financing Review*, 15 (4), 21-31.
- Stout, A.(1997). Prenatal care for low-income women and the health belief model: A new beginning. *Journal of Community Health Nursing*, 14(3), 169-180.
- Mahon, J. McFarlane, J., &Golden, K. (1991) De madres a madres: A community partnership for health. *Public Health Nursing*, 8(1), 15-19.
- The David and Lucile Packard Foundation, *The Role of Prenatal Care in Preventing Low Birth Weight*, Volume 5, No. 1, Spring 1995. See www.futureofchildren.org
- The National Institute of Health, National Institute of Nursing Research, *Community-Based Health Care: Nursing Strategies* www.nih.gov/ninr/research/vol7
- Teen Risk Taking: Promising Prevention Programs and Approaches: The Urban Institute. September 2000.

Decrease the rate of births (per 1,000) to teenagers aged 15-17.

The reasons teens become pregnant are complex. They include poverty, little hope for the future, the desire to be loved and to love, pressure from an older male, lack of decision making skills, inability to resist peer pressure, violence and abuse, engagement in other high risk behaviors, and provocative portrayals of sexuality by the media.

Research indicates that teens are less likely to become pregnant if they have close, positive connections with caring adults, have life opportunities and goals, use contraceptives if sexually active, and are doing well in school.

Pregnant and parenting teens are at risk for dropping out of school, not completing high school or post secondary schooling, having another baby, and not finding employment at a livable wage.

Adolescents should be encouraged to delay sexual intercourse until they are physically, cognitively, and emotionally ready for mature sexual relationships. They should receive education about intimacy, setting limits, resistance to social, media, peer and partner pressure; benefits of abstinence from intercourse and prevention of pregnancy and STD'S. (Healthy People 2010)

Systems Development:

- Provide leadership to and develop capacity of community organizations to obtain information on the local populations perceptions of health problems and health needs of teens.
- Monitor health status of community to identify geographic and economic regions that have the highest rates of births to teens.
- Work with the community of interest to identify potential barriers for adolescents receiving education regarding intimacy, setting limits, resistance to social media, peer and partner pressure; benefits of abstinence from intercourse and prevention of pregnancy and STD'S.
- Establish community health status baseline levels against which to set targets and measure achievement of quality benchmarks.
- Collaborate with community groups and families to identify the community specific nature of needed health education materials/ resources regarding teen pregnancy
- Serve as an information clearinghouse for local coalitions.
- Establish local partnerships involving parents, consumers, private providers and public agencies to develop consensus on issues related to teen pregnancies and adolescent health needs.
- Provide MCH leadership in the development of non-biased culturally appropriate health promotion messages and materials regarding the unique needs of adolescents.
- Educate local providers and consumers about the availability of health promotion resources from community, state and federal sources.
- Develop and disseminate standardized education information for community leaders, parents, teachers, community members, churches and civic groups regarding the importance of adolescent health needs.

Decrease the rate of births (per 1,000) to teenagers aged 15-17. (Continued)

- Disseminate results of research and demonstration projects to health care providers and community leaders.
- Collaborate with ethnic groups and community based organizations and private providers to address the training needs with respect to cultural competency and culture-specific health problems of adolescents.
- Work with others to identify culturally, linguistically, economically or geographically isolated individuals/families and link to resources.
- Assure low-cost comprehensive family planning services designed to meet the cultural, and age needs of the client.
- Develop and disseminate community resource directories. Collaborate with agencies and private companies working to develop such materials on an ongoing basis. Ensure translation of resource directories into other languages.
- Provide training and consultation to local provider groups regarding working with adolescents.

References and Best Practices:

- Montessoro, A. & Blixen, C. (1996). Public Policy and Adolescent Pregnancy: A Reexamination of the Issues. *Nursing Outlook*, pp. 31-36.
- What Works, Preventing Teen Pregnancy in Your Community (December 1999). www.ahs.state.vt.us/whtwks/wwteenpreg.pdf
- What Works: Keeping Youth in School in Your Community, (May 1999). www.ahs.state.vt.us/whtwks/wwschool.pdf.
- The David and Lucile Packard Foundation, *The Role of Prenatal Care in Preventing Low Birth Weight*, Volume 5, No. 1, Spring 1995. See www.futureofchildren.org
- The National Institute of Health, National Institute of Nursing Research, Priority Expert Panel on Community Based Health Care The National Institute of Health, National Institute of Nursing Research, *Community-Based Health Care: Nursing Strategies* www.nih.gov/ninr/research/vol7
- Eisen, M.; Pallitto, C.; Braddner, C.; & Bolshun, N. (September 2000). Teen Risk Taking: Promising Prevention Programs and Approaches. The Urban Institute: www.urban.org.
- Centers for Disease Control and Prevention, Division of Adolescent and School Health - Programs That Work. The Programs That Work are identified as examples of programs that have been proven effective in reducing risk behaviors for HIV, STD, and Pregnancy. Curriculum fact sheets, evaluation fact sheets and ordering information for the following curricula be viewed at www.cdc.gov/nccdphp/dash/rtc/hiv-curric.htm
 - Be Proud! Be Responsible: Strategies to Empower Youth to Reduce Their Risk of AIDS
 - Get Real About AIDS
 - Reducing the Risk: Building Skills to Prevent Pregnancy, STDs and HIV
 - Becoming a Responsible Teen
 - Focus on Kids: HIV Awareness

Decrease the rate of births (per 1,000) to teenagers aged 15-17. (Continued)

- The Guide to Community and Preventative Services (the Community Guide) Sexual Behavior Chapter on HIV, STD, And Unintended Pregnancy Prevention will summarize the published evidence on effectiveness of populations-based recommendation and local needs, goals and constraints when choosing appropriate interventions. Anticipated date of Publication: Fall 2002. www.thecommunityguide.org.
- Knowledge Path: Adolescent Pregnancy Prevention (October 2001)
www.ncemch.org/RefDes/kpadolpreg.html

Publications and resources are available from the following:

- Advocates for Youth. www.advocatesforyouth.org
- The Annie E. Case Foundation. www.aecf.org
- Center for Adolescent Health, University of Minnesota – *Protecting Teens: Beyond Race, Income and Family Structure*. To order, E-mail: aph@umn.edu
- Child Trends. 4301 Connecticut Ave. NW, Suite 100, Washington D.C., 20008. Phone 202/362-5580. www.childrends.org
- Department of Health and Human Service – *A National Strategy to Prevent Teen Pregnancy*. www.aspe.hhs.gov/hsp/teenp/
- Konopka Institute for Best Practices in Adolescent Health and the National Teen Prenancy Prevention Research Center — University of Minnesota, University Gateway, 200 Oak St. SE Suite 260, Minneapolis, MN 55455. The institute focuses on some of the major threats to young people: violence, tobacco, alcohol and teen pregnancy. www.konopka.umn.edu
- National Association of State Boards of Education (NASBE) – The Impact of Adolescent Pregnancy and Parenthood on Educational Achievement. www.nasbe.org
- National Campaign to Prevent Teen Pregnancy. www.teenpregnancy.org
- The National Adolescent Health Information Center (NAHIC) serves as a national resource for adolescent health research and health-related information. University of California, San Francisco, School of Medicine, Division of Adolescent Medicine, Department of Pediatrics and Institute of Health Policy Studies, UCSF Box 0503, San Francisco, CA 94143. www.youth.ucsf.edu/nahic Information and Fact Sheets available:
 - Adolescent Demographic
 - Adolescent Homicide
 - Adolescent Mortality
 - Adolescent Sexuality
 - Adolescent Suicide
 - Investing in Preventive Health Services for Adolescent
 - Adolescent HealthCare Utilization
 - Adolescent Pregnancy Prevention: Effective Strategies
 - Adolescent Substance Abuse

Decrease the percent of live births to females with less than 12 years of education.

According to Healthy People 2010, the average level of education in the U.S. population has increased steadily over the past several decades, an important achievement given that more years of education usually translate into more years of life. For women, the amount of education achieved is a key determinant of the welfare and survival of their children. Higher levels of education may also increase the likelihood of obtaining or understanding health related information needed to develop health promoting behaviors and beliefs in prevention. Research shows that teens that are pregnant are at great risk for dropping out of school, not completing school or post secondary schooling, not finding employment at a livable wage.

Systems Development:

- Provide leadership to and develop capacity of community organizations to obtain information on the local populations perceptions of health problems and health needs and determinants of health.
- Function as active and integral participant in the identification of special populations at risk.
- Analyze surveillance and other data to identify patterns and high-risk populations.
- Establish community health status baseline levels against which to set targets and measure achievement of quality benchmarks.
- Ensure that education materials are culturally/linguistically appropriate. Collaborate with ethnic groups and community based organization, and private providers to address training needs with respect to cultural competency and culture-specific health problems.
- Initiate community collaboration projects to address needs identified. .
- Work with others to identify culturally, linguistically, economically or geographically isolated individuals/families at risk.
- Participate on advisory committees in state/local agencies developing pregnancy prevention initiatives/dropping out of school initiatives and GED completion initiatives.
- Monitor and evaluate on a continuing basis.
- Coordinate prevention activities with others to prevent adolescents from dropping out of school.

Best Practices

- What Works: Preventing Teen Pregnancy in Your Community (December 1999). www.ahs.state.vt.us/whtwks/wwteenpreg.pdf.
- What Works: Keeping Youth in School in Your Community, (May 1999). www.ahs.state.vt.us/whtwks/wwschool.pdf.
- The National Institute of Health, National Institute of Nursing Research, *Community-Based Health Care: Nursing Strategies* www.nih.gov/ninr/research/vol7
- Eisen, M.; Pallitto, C.; Braddner, C; & Bolshun, N. (September 2000). Teen Risk Taking: Promising Prevention Programs and Approaches. The Urban Institute: www.urban.org.
- Programs That Work may be viewed online at www.cdc.gov/nccdphp/dash/rtc

Decrease the percent of live births to females with less than 12 years of education.

(Continued)

- The Guide to Community and Preventative Services (the Community Guide) Chapter on HIV, STD, And Unintended Pregnancy Prevention will summarize the published evidence on effectiveness of populations-based recommendation and local needs, goals and constraints when choosing appropriate interventions. Anticipated date of Publication: Fall 2002. www.thecommunityguide.org.
- Knowledge Path: Adolescent Pregnancy Prevention (October 2001) www.ncemch.org/RefDes/kpadolpreg.html
- National Association of State Boards of Education (NASBE) – The Impact of Adolescent Pregnancy and Parenthood on Educational Achievement. www.nasbe.org

Decrease the percent of births weighing less than 2,500 grams.

Approximately two-thirds of the low birth weight (LBW) and 98% of the very low birth weight (VLBW) infants are born preterm. Preterm birth is associated with a number of modifiable risk factors, including the use of alcohol, tobacco, or other drugs during pregnancy, and low pre-pregnancy weight or low weight gain during pregnancy. Other important risk factors for preterm births are vaginal infections and domestic violence.

The most effective ways to prevent LBW and VLBW infants are to promote healthy behaviors before and during pregnancy and to identify women early in pregnancy who are at risk of preterm labor, LBW or both.

Large disparities exist between racial, ethnic, age and socioeconomic groups regarding access to prenatal care and healthy babies. Uninsured, low-income, teens, racial and ethnic minorities, and undocumented aliens are less likely to obtain prenatal care and more likely to have LBW babies.

Tobacco use is the most preventable cause of LBW. Teenagers, women who are white, have less than a high school education, are unmarried or who are low income, are significantly more likely to use tobacco. Fifty-four percent of smokers continue to smoke after learning of pregnancy.

Systems Development:

- Monitor health status of community to identify geographic and economic regions that have the highest rates of late entry into prenatal care.
- Provide leadership to and develop capacity of community organizations to obtain information on the local populations perceptions of health problems and health needs.
- Establish local partnership mechanisms involving consumers, private providers and public agencies to address needs identified.
- Work with the community of interest to identify potential barriers to prenatal care. Function as active and integral participant in the identification of special populations at risk.
- Establish community health status baseline levels against which to set targets and measure achievement of quality benchmarks.
- Conduct public education programs about the importance of first trimester care, good nutrition and abstinence from tobacco and alcohol and other drugs. Target the communities at highest risk.
- Participate on advisory committees in state/local agencies related to entry into prenatal care.
- Assure low-cost comprehensive family planning services designed to meet the cultural, and age needs of the client.
- Provide outreach services (including home visiting) particularly to uninsured and other hard to reach populations.
- Develop and disseminate community resource directories. Collaborate with agencies and private companies working to develop such materials on an ongoing basis. Ensure translation of resource directories into other languages.

Decrease the percent of births weighing less than 2,500 grams. (Continued)

- Collaborate with other agencies and community partners to identify at risk populations and provide services that maximize services and avoid duplication of efforts.
- Provide culturally appropriate education programs for public health nurses and educators.
- Work with community to increase abstinence from alcohol, tobacco and illicit drugs among pregnant women.
- Work with the faith community to assist racial and ethnic minority women in learning about the availability of early prenatal care.
- Conduct public education programs about the importance of first trimester care.
- Create and disseminate education messages promoting the concept of no primary or secondary tobacco exposure, no alcohol or other drug use during pregnancy or while parenting or care taking.
- Disseminate culturally appropriate materials in community settings.
- Ensure translation of programs/messages to targeted ethnic groups.
- Encourage local media to publicize effects of smoking during pregnancy.
- Encourage health care providers to screen for domestic violence and refer into a system of care.
- Encourage health care providers to screen for tobacco use and assist with tobacco cessation programs.

Best Practices/References:

- da Silva, O. (1998). Prevention of Low Birth Weight/Preterm Birth. www.ctfphc.org
- Bauer, P. (1998). Recipient and provider perspectives to rural prenatal care. *Journal of Community Health Nursing*, 15 (4), 237-249.
- Henderson, J. (1994). The cost effectiveness of prenatal care. *Health Care Financing Review*, 15 (4), 21-31.
- Stout, A.(1997). Prenatal care for low-income women and the health belief model: A new beginning. *Journal of Community Health Nursing*, 14(3), 169-180.
- Mahon, J. McFarlane, J., &Golden, K. (1991) De madres a madres: A community partnership for health. *Public Health Nursing*, 8(1), 15-19.
- The David and Lucile Packard Foundation, *The Role of Prenatal Care in Preventing Low Birth Weight*, Volume 5, No. 1, Spring 1995. See www.futureofchildren.org
- The National Institute of Health, National Institute of Nursing Research, Priority Expert Panel on Community Based Health Care The National Institute of Health, National Institute of Nursing Research, *Community-Based Health Care: Nursing Strategies* www.nih.gov/ninr/research/vol7
- The Guide to Community Preventative Services (The Community Guide) provides decision makers with recommendations regarding population-based interventions to promote health and to prevent disease, injury, disability and premature death, appropriate for use by communities and health care systems. (For more information about the Community Guide, including links to a variety of resources, go to www.thecommunityguide.org. The

Decrease the percent of births weighing less than 2,500 grams. *(Continued)*

Tobacco Use Prevention chapter summarizes the published evidence on effectiveness of interventions to prevent product use initiation, to increase tobacco use cessation, and to reduce exposure to environmental tobacco smoke. To review the Tobacco Use Prevention Chapter on line go to www.cdc.gov/mmwr/preview/mmwrhtml/rr4912a1.htm

- MMWR 2000 49:RR-12.: Strategies for Reducing Exposure to Environmental Tobacco Smoke, Increasing Tobacco-Use Cessation, and Reducing Initiation in Communities and Health Care Systems. www.cdc.gov/mmwr/preview/mmwrhtml/rr4912a1.htm
- Environmental tobacco smoke. To review Tobacco Use Prevention Chapter on line go to www.cdc.gov/mmwr/preview/mmwrhtml/rr4912a1.htm
- ACHRP recommendations for clinicians: www.ahcpr.gov/reseach/apr96/dept8.htm
- AHCPR recommendations for smokers who want to quit: www.ahcpr.gov/clinic/toolskit.htm.
- Ebrahim, S., Floyd, R., Merritt, R., Declufle, P. Holtzman, D., (2000) Trends in Pregnancy-related smoking rates in the US.1987-1996. *Journal of the American Medical Association*, 283 (3) 1113-1117.
- Promoting Optimal Prenatal Care for Healthy Birth Outcomes (September 2000), Oregon Health Division, Center for Child and Family Health. www.ohd.hr.state.or.us/ccfh/pren.pdf.
- Knowledge Path: Infant Mortality (June 2000) National Center for the Education of Maternal and Child Health www.ncemch.org/RefDes/infmortKP.html

Decrease the infant mortality rate per 1,000.

The infant mortality rate is made up of two components: neonatal mortality (death in the first 28 days of life) and post-neonatal mortality (death from the infants' 29th day but within the first year). The leading causes of neonatal death include birth defects, disorders related to short gestation and LBW, and pregnancy complications. Of these, the most likely to be preventable are those related to preterm birth and LBW, which represent approximately 20% of neonatal deaths. (Healthy People 2010)

Post-neonatal death reflects events experienced in infancy, including SIDS, birth defects, injuries and homicide. Birth defects, many of, which are unlikely to be preventable, given current scientific knowledge, account for approximately 17 percent of post neonatal deaths; the remainders are likely to stem from preventable causes.

LBW is the risk factor most closely associated with neonatal death; thus, improvement in infant birth weight can contribute substantially to reductions in the infant mortality rate. Smoking accounts for 20 to 30 percent of LBW births in the US.

SIDS is the leading cause of post-neonatal death among all racial and ethnic groups, representing nearly one-third of all cases of post-neonatal deaths

Infant mortality rate is almost double for infants of mothers with less than 12 years of education compared to those with an education of 13 or more years. (Healthy People 2010)

Systems Development:

- Monitor health status of community to identify geographic and economic regions that have the highest rates of late entry into prenatal care.
- Provide leadership to and develop capacity of community organizations to obtain information on the local populations perceptions of health problems, health needs, and determinants of health.
- Establish local partnership mechanisms involving, consumers, private providers and public agencies to address needs identified.
- Work with the community of interest to identify potential barriers to prenatal care. Function as active and integral participant in the identification of special populations at risk.
- Establish community health status baseline levels against which to set targets and measure achievement of quality benchmarks.
- Conduct public education programs about the importance of first trimester care, good nutrition and abstinence from tobacco and alcohol and other drugs. Target the communities at highest risk.
- Participate on advisory committees in state/local agencies related to entry into prenatal care.
- Assure low-cost comprehensive family planning services designed to meet the cultural, and age needs of the client.
- Provide outreach services (including home visiting) particularly to uninsured and other hard to reach populations.

Decrease the infant mortality rate per 1,000. (*Continued*)

- Develop and disseminate community resource directories. Collaborate with agencies and private companies working to develop such materials on an ongoing basis. Ensure translation of resource directories into other languages.
- Collaborate with other agencies and community partners to identify at risk populations and provide services that maximize services and avoid duplication of efforts.
- Provide culturally appropriate education programs for public health nurses and educators.
- Work with community to increase abstinence from alcohol, tobacco and illicit drugs among pregnant women.
- Work with the faith community to assist racial and ethnic minority women in learning about the availability of early prenatal care.
- Conduct public education programs about the importance of first trimester care.
- Create and disseminate education messages promoting the concept of no primary or secondary tobacco exposure, no alcohol or other drug use during pregnancy or while parenting or care taking.
- Disseminate culturally appropriate materials in community settings.
- Ensure translation of programs/messages to targeted ethnic groups.
- Encourage local media to publicize effects of smoking during pregnancy.

Best Practices/References

- da Silva, O. (1998). Prevention of Low Birth Weight/Preterm Birth. www.ctfphc.org
- Bauer, P. (1998). Recipient and provider perspectives to rural prenatal care. *Journal of Community Health Nursing*, 15 (4), 237-249.
- Mahon, J. McFarlane, J., & Golden, K. (1991) De madres a madres: A community partnership for health. *Public Health Nursing*, 8(1), 15-19.
- The David and Lucile Packard Foundation, *The Role of Prenatal Care in Preventing Low Birth Weight*, Volume 5, No. 1, Spring 1995. See www.futureofchildren.org
- The National Institute of Health, National Institute of Nursing Research, *Community-Based Health Care: Nursing Strategies* www.nih.gov/ninr/research/vol7
- The Guide to Community Preventative Services (The Community Guide) provides decision makers with recommendations regarding population-based interventions to promote health and to prevent disease, injury, disability and premature death, appropriate for use by communities and health care systems. (For more information about the Community Guide, including links to a variety of resources, go to www.thecommunityguide.org).
- The Tobacco Use Prevention chapter summarizes the published evidence on effectiveness of interventions to prevent product use initiation, to increase tobacco use cessation, and to reduce exposure to environmental tobacco smoke.
- Environmental tobacco smoke. To review Tobacco Use Prevention Chapter on line go to www.cdc.gov/mmwr/preview/mmwrhtml/rr4912a1.htm
- ACHRP recommendations for clinicians: www.ahcpr.gov/research/apr96/dept8.htm

Decrease the infant mortality rate per 1,000. *(Continued)*

- AHCPR recommendations for smokers who want to quit: www.ahcpr.gov/clinic/toolskit.htm.
- Ebrahim, S., Floyd, R., Merritt, R., Declufle, P. Holtzman, D., (2000) Trends in Pregnancy-related smoking rates in the US.1987-1996. Journal of the American Medical Association, 283 (3) 1113-1117.
- Knowledge Path: Infant Mortality (June 2000) National Center for the Education of Maternal and Child Health www.ncemch.org/RefDes/infmortKP.html
- The guide to Community Preventative Services (The Community Guide) will summarize the published evidence on effectiveness of populations-based interventions that have been used in communities to prevent HIV, STD, and unintended pregnancy. Anticipated date of publication: Fall 2002. www.thecommunityguide.org
- Promoting Optimal Prenatal Care for Healthy Birth Outcomes (September 2000), Oregon Health Division, Center for Child and Family Health. www.ohd.hr.state.or.us/ccfh/pren.pdf.
- The Best Intentions: Unintended Pregnancy and the Wellbeing of Children and Families. 1995, Washington, D.C., National Academy Press.
- Henderson, J. (1994). The cost effectiveness of prenatal care. Health Care Financing Review, 15 (4), 21-31.
- Stout, A. (1997). Prenatal care for low-income women and the health belief model: A new beginning. Journal of Community Health Nursing, 14(3), 169-180.

Increase the percent of Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen (EPSDT).

The goals of well-baby care are to: 1.) Immunize, 2.) Provide parents with reassurance and counseling on safety, nutrition and behavioral problems; and 3) Identify and treat physical, developmental and parenting problems. The goal of health supervision during infancy is to help the parents gain knowledge and confidence in caring for the physical, intellectual and emotional needs of their infant.

The Healthy Children and Youth (HCY) program recommends checkups at 2 to 3 days; by one month; 2 to 3 months; 4 to 5 months; 6 to 8 months; and 9 to 11 months.

Strategies:

- Collect data regarding EPSDT screens in the community.
- Identify potential barriers for infants and children receiving adequate EPSDT screens.
- Work with health care providers, parents and community leaders to address barriers identified.
- Conduct public awareness campaigns for parents regarding the importance of EPSDT screens.
- Provide MCH leadership in the development of non-biased, culturally appropriate health promotion messages and materials regarding EPSDT screens.
- Establish links with community leaders and others to identify culturally/linguistically or geographically isolated families.
- Collaborate with agencies providing services to families and infants to include EPSDT information.

Best Practices:

- Well-baby Care in the First 2 years of Life (1994) Canadian Task Force on Preventative Health Care www.ctfphc.org
- Knowledge Path: Child Health Insurance and Access to Care (June 2001) www.ncemch.org/RefDes/InsuranceKP.html

Decrease the percent of children without health insurance.

According to a national survey published January 2000 by the Henry J Kaiser Foundation. It is estimated that 4.7 million children in the U.S. are uninsured and potentially eligible for Medicaid. Due to the unaffordability of services, parents of eligible uninsured children are more likely than Medicaid enrolled parents to postpone health care (41% to 16%); seek medical care for their child even when they could not afford it (45% to 23%); and not fill a prescription for their child because they could not afford it (26% to 13%).

Systems Interventions:

- Monitor the health status of the community to identify geographic and economic regions that have the potential for children without health insurance.
- Function as an active and integral participant in the identification of special population at risk.
- Establish community health status baseline levels against which to set targets and measure benchmarks.
- Work with churches, civic groups, community leaders and educators, and others to link children to health insurance.
- Ensure that outreach materials are culturally/linguistically appropriate.
- Monitor interventions on a regular basis.

Best Practices:

- Knowledge Path: Child Health Insurance and Access to Care (June 2001)
www.ncemch.org/RefDes/InsuranceKP.html
- Medicaid and Children: Overcoming Barriers to Enrollment (January 2000)
www.kff.org/content/2000/2174
- The David and Lucile Packard Foundation, *Children and Managed Health Care*, Volume 8, No 2, Spring 1998. See www.futureofchildren.org/usr_doc/vol8no2%2Epdf

Increase the percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Hib, and Hepatitis B.

According to Healthy People 2010, vaccines are among the greatest public health achievements of the 20th century. Immunizations can prevent disability and death from infectious diseases for individuals and can help control the spread of infections within communities. In 1998, 73 percent of children received all vaccines recommended for universal administration.

Systems Development

- Assess current levels of vaccination rates.
- Analyze surveillance and other data to identify patterns and high-risk populations.
- Assess strategies currently being performed.
- Assess causes for under-immunization.
- Review scientific evidence to identify best practices.
- Initiate community collaboration projects that address local needs identified.
- Develop interventions that address local problems.
- Function as active and integral participant in the identification of special populations at risk.
- Establish community health status baseline levels against which to set targets and measure achievement of quality benchmarks.
- Ensure that education/outreach materials are culturally/linguistically appropriate. Collaborate with ethnic groups and community based organization, and private providers to address training needs with respect to cultural competency and culture-specific health problems.
- Work with others to identify culturally, linguistically, economically or geographically isolated individuals/families at risk.
- Monitor and evaluate on a continuing basis.
- Assure immunizations are accessible.

Best Practices:

- The Guide to Community Preventative Services (The Community Guide) published recommendations for interventions to increase vaccination coverage rates. See MMWR 1999 48; RR-8. In addition to evidence of effectiveness and recommendations, the chapter describes applicable differences in the evidence of effectiveness for different populations and settings. To review Oral Health Chapter on line, go to www.thecommunityguide.org
- Schefer, A.M., Briss, P.A., Rodewald, L. (1999) Improving Immunization coverage rates: and evidenced based review of the literature. Epidemiological Review.
- Task Force on Community Preventative Services (2000). Recommendations regarding interventions to improve vaccination coverage in children, adolescents and adults. American Journal of Preventative Medicine, 18(1S): 92-96.

Increase the percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Hib, and Hepatitis B.
(Continued)

Strategies:

- Assessment, Feedback, Incentives, Exchange (AFIX)
 - Assessment: Assess each provider in the LPHA's jurisdiction who administers immunizations to children under two years of age. Suggested intervention: Clinic Assessment Software Application (CASA).
 - Feedback: Meet face-to-face with provider and encourage provider to use all opportunities to vaccinate, follow only valid contraindications, simultaneously administer vaccines, and record immunizations in one place. Suggested intervention: Immunization Consent and History form.
 - Incentives: Should be timely, valued, for all clinic staff, and publicized.
 - Exchange: Providers should exchange information about strategies that work to increase immunization rates.
- Reminder/Recall
 - From LPHAs to Private Providers:
Reminder: Provider informed before or at time of patient's office visit that immunizations are due soon. Suggested interventions: Computer-generated lists, notes in charts.
Recall: Provider informed before or at time of patient's office visit that immunizations are past due. Suggested interventions: Computer-generated lists, notes in charts.
 - From LPHAs to Parents:
Reminder: Delivered close to due date for vaccinations. Suggested interventions: postcards, letters, phone calls, autodialer calls.
Recall: Delivered promptly if scheduled visit missed. Suggested interventions: postcards, letters, phone calls, autodialer calls.
- Screening WIC Participants
 - Assess the immunization status of each WIC participant under two years of age at every WIC visit, and for underimmunized children, provide vaccinations on-site or refer to a healthcare provider.
- Continuing Education
 - For Private Providers:
 - Offer ongoing education to providers, in conjunction with AFIX and/or Reminder/Recall.
 - Suggested intervention: multifaceted approach.
 - For Parents:
 - Offer ongoing education to parents, in conjunction with AFIX and/or Reminder/Recall.
 - Suggested intervention: multifaceted approach.

Increase the percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Hib, and Hepatitis B.
(Continued)

- OPTIONAL PRACTICES

- Ensure immunization information on children under two years of age in the LPHA's jurisdiction is entered into the statewide immunization registry (MOHSAIC). This can include providing MOHSAIC training and limited support to private physicians.
- Encourage private physicians to participate in the Vaccines for Children (VFC) program.
- Provide community education
 - Display posters and distribute brochures at community-based sites
 - Collaborate/consult with organizations, pre-schools, Head Start, childbirth educators, Welcome Wagon, Parents as Teachers and other home visiting programs to get information to families
 - Follow up on newborns
- Develop transportation vouchers to address transportation needs for families.

Increase the percent of third grade children who have received protective sealant on at least one permanent molar tooth.

According to Healthy People 2010 Objectives, - caries is one of the most prevalent infectious diseases known. It is now the leading chronic infectious disease of children, surpassing asthma five-fold.

Research Findings:

- Fluoridation of community water systems is the most effective prevention strategy.
- Parents who know more about child oral health preventative care can help prevent dental caries.
- All children should receive dental sealants on their first permanent molars.
- The National Institutes of Health position paper states that, " The placement of sealants is a highly effective means of preventing pit fissure caries. It is safe. It is currently underused in both private and public dental health care delivery systems. Expanding the use of sealants would substantially reduce the occurrence of dental caries in the population beyond that already achieved by fluoride and other preventative measures." (NIH Consensus Statement 1983)
- The task force on Community Preventative Services strongly recommends school based sealant delivery interventions.

Systems Development:

- Establish links with local and state organizations to secure comprehensive information on key dental health indicators for the community.
- Identify missing community specific data. Seek clarification of data.
- Assess the availability of community resources and community organizations.
- Establish community health status baseline levels against which to set targets and measure achievements of quality benchmarks.
- Develop reports/issue briefs on the dental health status of the community.
- Inform the community regarding the dental health status of the community and collaborate with community groups to educate local providers and consumers about the availability of dental sealant resources.
- Develop and disseminate educational packets to non-dental healthcare providers about dental sealants, and the health consequences of dental caries.
- Develop public information programs regarding dental sealants for parents.
- Develop parent education programs for schools and day care settings and home visiting programs regarding good dental health.
- Establish local partnership mechanisms involving parents, consumers, private providers, schools and public agencies to address the oral health needs of children.

Increase the percent of third grade children who have received protective sealant on at least one permanent molar tooth. *(Continued)*

- Develop public information campaign and media awareness on dental sealants in collaboration with dental schools, dental society and other partners. Disseminate culturally/linguistically appropriate outreach materials in community settings.
- Collaborate with other agencies in the development and dissemination of dental health resource directories.
- Encourage school health programs to record number of students with dental sealant in cumulative health record.
- Encourage community partnership with school and others to administer dental sealant in the school setting.
- Assure that children/parents in alternate school settings have access to dental sealant programs.
- Assure children with and without health insurance have access to dental health services.
- Monitor and evaluate dental sealant program on a continual basis.

Best Practices:

- Knowledge Path: Oral Health and Children (February 2001)
www.ncemch.org/RefDes/kporalhealth.html
- Oral Health Plan for Children (September 2000), Oregon Health Division, Center for Child and Family Health www.ohd.hr.state.or.us/ccfh/oral2.pdf
- The Guide to Community Preventative Services (The Community Guide) provides decision makers with recommendations regarding population-based interventions to promote health and to prevent disease, injury, disability and premature death, appropriate for use by communities and health care systems. (For more information about the Community Guide, including links to a variety of resources, go to www.thecommunityguide.org). The Promoting Oral Health Chapter will summarize the published evidence on effectiveness of interventions to improve oral health. In additions to a set of recommendations, the chapter aims to promote oral health among public health professionals.
- Basic Screening Surveys: *An Approach to Monitoring Community Oral Health*. The Association of State and Territorial Dental Directors (ASTDD) has developed training materials that can be used by screeners with or without dental backgrounds to assess for the presence of dental sealants, dental caries or oral lesions. The training package includes the following: a training manual; screening training video; data collections forms for preschool children, school children and adults; Reference Guide for Screening; and data entry diskette for direct entry of evaluation data into Epi Info software. For additional information or to order materials, contact Dean Perkins, D.D.S., Missouri Department of Health and Senior Services, Center for Health Improvement, P.O. Box 570, Jefferson City, MO 65102. Phone: 573/751-6247.

Increase the percent of children aged one to six years tested for lead poisoning.

Childhood lead poisoning is one of the most common pediatric health problems in the United States, and it is entirely preventable. Missouri is the #1 lead producing state in the United States. Current data shows that the proportion of Missouri children with elevated blood lead levels is three times higher than the national average. Enough is now known about the sources and pathways of lead exposure and about ways of preventing this exposure to begin the efforts to eradicate permanently this disease. The persistence of lead poisoning in light of all that is known, presents a singular and direct challenge to public health authorities, clinicians, regulatory agencies and society (CDC, 10/1991).

The most common source of lead poisoning in children comes from the dusting and chipping of deteriorating lead based paint. More than 80% of the housing stock in Missouri was build prior to 1978 when federal laws required the reduction of lead in house paint to non-harmful levels (Missouri Department of Health).

Systems Development:

- Provide leadership to and develop capacity of community organizations to obtain information on the local populations perceptions of health problems and health needs.
- Monitor health status of the community to identify geographic and economic regions that have the potential to be at greatest risk for lead exposure. Target interventions to these communities.
- Establish community health status baseline levels against which to set targets and measure achievement of quality benchmarks.
- Develop and disseminate standardized lead education information for parents, teachers, community members, realtors, churches and civic groups.
- Ensure that education materials are culturally/linguistically appropriate. Collaborate with ethnic groups and community based organization, and private providers to address training needs with respect to cultural competency and culture-specific health problems.
- Initiate community collaboration projects.
- Educate local health care providers about lead poisoning and Medicaid guidelines for testing.
- Increase property owners', managers' and tenants' knowledge of the dangers of lead poisoning to young children.
- Work with others to identify culturally, linguistically, economically or geographically isolated individuals/families with children at risk for lead exposure and ensure blood lead testing.
- Encourage local media to publicize lead education program.
- Identify barriers to lead testing. Work with others to address barriers.
- Disseminate results of research and demonstration projects.
- Participate on advisory committees in state/local agencies developing policies related to lead safe housing.
- Work with schools and school nurses. Encourage school nurses to add a question on kindergarten health history regarding lead testing.

Increase the percent of children aged one to six years tested for lead poisoning.
(Continued)

- Work with day care centers to include history of lead testing on health history form.
- Ensure that necessary screening/testing services are provided.
- Analyze surveillance and other data to identify exposure patterns and high-risk populations.
- Work with local health care providers to assure that lead testing is performed on all children under the age of 6 according to state guidelines.
- Monitor and evaluate on a continuing basis.
- Coordinate prevention activities with other pertinent health, housing and environmental agencies.
- Ensure that medical and environmental follow-up services are provided.

Best Practices:

- Preventing Lead Poisoning in Young Children at aepo-xdv-www.epo.cdc.gov/wonder/prevguid/p0000029/p0000029.asp
- MMWR December 8, 2000. Vol. 49 No RR-14, Recommendations for Blood Lead Screening of young Children Enrolled in Medicaid: Targeting a Group at High Risk.
- Centers for Disease Control and Prevention, National Center of Environmental Health: www.cdc.gov/nceh/default.htm
- Agency for Toxic Substance and Disease Registry (case studies, education for parents, teachers, children and medical professionals): www.atsdr.cdc.gov
- National Environmental Education and Training Foundation: www.neetf.org
- Children's Environmental Health Network (resources, education, links, recent legislation, Pediatric Training Manual): www.cehn.org

Decrease the percent of children who are obese.

According to *Healthy People 2010*, there is much concern about the increasing prevalence of obesity in children and adolescents. Overweight and obesity acquired during childhood or adolescence may persist in to adulthood and increase the risk for some chronic diseases later in life.

Patterns of healthful eating behavior need to begin in childhood and be maintained throughout adulthood. Regular physical activity is linked to enhanced health and to reduce risk for all-cause mortality and the development of many chronic diseases. School and community programs have the potential to help children and adolescents establish lifelong, healthy physical activity patterns.

Systems Development:

- Provide leadership to and develop capacity of community organizations to obtain information on the local populations perceptions of health problems and health needs.
- Function as active and integral participant in the identification of special populations at risk.
- Establish community health status baseline levels against which to set targets and measure achievement of quality benchmarks.
- Assess the available community resources.
- Develop and disseminate standardized education information for parents, teachers, community members, churches and civic groups regarding the health consequences of obesity.
- Disseminate results of research and demonstration projects
- Ensure that education materials are culturally/linguistically appropriate. Collaborate with ethnic groups and community based organization, and private providers to address training needs with respect to cultural competency and culture-specific health problems.
- Initiate community collaboration projects.
- Work with others to identify culturally, linguistically, economically or geographically isolated individuals/families with children at risk for obesity.
- Encourage local media to publicize information regarding the health consequences of obesity for children.
- Participate on advisory committees in state/local agencies developing obesity initiatives.
- Partner with schools, day care providers, home visiting program staff, parents as first teachers and health educators to develop nutrition messages for parents and students.
- Analyze surveillance and other data to identify patterns and high-risk populations
- Monitor and evaluate on a continuing basis
- Coordinate prevention activities with other pertinent health, housing and environmental agencies. (safe and accessible playgrounds, lighted walking paths, bicycle paths, etc)

Policy and Environmental Support Resources:

- *Fit, Health, and Ready to Learn Part I: Physical Activity, Health Eating, and Tobacco-Use Prevention – A School Health Policy Guide*. 2000. National Association of State Boards of Education (NASBE). 277 South Washington Street, Suite 100, Alexandria, VA 22314, 1-800/220-5183. \$22.00 plus \$4.00 shipping and handling.

Decrease the percent of children who are obese. (Continued)

- *Changing The Scene: Improving the School Nutrition Environment*. 2001. Tools and strategies for improving the school nutrition environment. Team Nutrition, Food and Nutrition Service, U.S. Department of Agriculture, 3101 Park Center Drive, Room 1010, Alexandria, VA 22302. 703/305-1624. One kit will be provided free of charge for each school. Order online at www.fns.usda.gov/tn
- *Health Policy Coach*. Provides tools and strategies for policy development in the eight components of Coordinated School Health, and in tobacco use prevention, physical activity, and health eating. Available only from the California Center for Health Improvement at www.healthpolicycoach.org
- *Guidelines for School and Community Programs to Promote Lifelong Physical Activity Among Young People*. 1997. Centers for Disease Control and Prevention, Division of Nutrition and Physical Activity and Division of Adolescent and School Health. www.cdc.gov/nccdphp/dash>Guidelines
- *Guidelines for School and Community Programs to Promote Lifelong Health Eating*. 1997. Centers for Disease Control and Prevention, Division of Nutrition and Physical Activity and Division of Adolescent and School Health. www.cdc.gov/nccdphp/dash>Guidelines
- *Promoting Better Health For Young People Through Physical Activity and Sports: A Report to the President from the Secretary of Health and Human Services and the Secretary of Education*. Fall 2000. www.cdc.gov/nccdhp/dash

Best Practices:

- Knowledge Path: Childhood Nutrition. (August 2001) This knowledge path on childhood nutrition sponsored by the NCEMCH provides a guide to resources on the Web site with links to others. Aimed at policymakers, health professionals, and researchers. www.ncemch.org/RefDes/kpchildnutr.html
- The Centers For Disease and Prevention's National Center for Chronic Disease and Prevention and Health Promotion: www.cdc.gov
- The President's Council on Physical Fitness and Sports. www.fitness.gov
- The Guide to Community Preventative Services (the Community Guide) physical activity chapter will summarize published evidence of population-based interventions that have been use in communities to promote increased levels of physical activity. See summary at www.thecommunityguide.org.
- MMWR 2001 50:RR-18: A Report on Recommendations of the Task Force on Community Preventive Services Increasing Physical www.cdc.gov/mmwr/preview/mmwrhtml/rr5018a1.htm
- Guidelines for School and Community Programs to Promote Lifelong Physical Activity Among Young People. MMWR Recommendations and Reports. March 17, 1997/Vol 46/No. RR6
- School Health Index for Physical Activity and Healthy Eating: A Self-Assessment and Planning Guide. February 2000, CDC (elementary school version and middle school /high school version) www.cdc.gov/nccdphp/dash/SHI/index.htm
- Bright Futures in Practice: Nutrition www.brightfutures.org/nutrition/index.html
- Screening for Childhood Obesity: Canadian Task Force on Preventative Health Care. www.ctfphc.org

Decrease the percent of children who are obese. *(Continued)*

- Evidenced-Based Physical Activity and Nutrition Interventions
 - Coordinated Approach To Cardiovascular Health (CATCH) – A multiple component program for students in grades 3-5 that includes: Classroom curricula to educate about physical activity and healthy eating; A physical education curriculum designed to maximize student activity during and increase participation outside of class; and A school nutrition program guide designed to assist the school food service program to provide healthy menu options. Evaluation results from more than 5,000 students in 100 elementary schools in four states found that students who participated in CATCH decrease self-reported daily energy intake from fat; increased the intensity of physical activity during physical education classes; and increased the amount of self-reported vigorous activity participation outside of school. A follow-up study found that three years after their last formal encounter with the CATCH lessons, almost 4,000 eighth graders in four states reported they continued to practice much of what they learned. Contact: 601 Flaghouse Drive, Hasbrouck Heights, NJ 07604. 800/793-7900. www.flaghouse.com
 - Planet Health – An interdisciplinary curriculum for students in grades 6-8 taught over a two-year period. Lessons focus on decreasing television viewing, decreasing consumption of high-fat foods and increasing moderate and vigorous physical activity. The materials are designed to fit within existing math, science, social studies, language arts, health and physical education curricula. Planet Health includes: 32 lesson plans (8 language arts, 8 math, 8 science, 8 social studies); 32 micro-units for physical education; and teacher planning and nutrition information. Result: Planet Health decreased television viewing among boys and girls, increased fruit and vegetable intake among girls, and reduced obesity among female students. Contact: Human Kinetics, PO Box 5076 Champaign, IL 61825-5076. 800/747-4457. www.humankinetics.com
 - Jump Start for Teens - An interdisciplinary curriculum for students in grades 9-12. Lessons cover healthy eating topics including reading food labels, cutting fat in fast food selections, and the importance of healthy eating for athletic performance. Lessons also included planning a personal physical activity program, advocating for healthy schools and communities, analyzing advertising messages, and working with the media. Student handouts are printed in both English and Spanish. A policy guide is also included to assist teens with becoming advocates to promote healthy eating and physical activity in their schools and communities. Evaluation in progress. Contact: California Project LEAN, PO Box 942732, NS-675, Sacramento, CA 94234-7320. 916/323-4742. Teen website: www.caprojectlean.org
 - SPARK – Physical Education curriculum for student in grades K-6. Results: Increased moderate-to-vigorous physical during PE classes. Contact: SPARK, 6363 Alvarado Court, Suite 250, San Diego, CA 92120. 800/SPARK-PE. www.foundation.sdsu.edu/projects/spark/
 - Know Your Body – A comprehensive health education curriculum covering personal and social skills through approximately 60 sessions per year in grades K-6. Results: Increased self-reported physical activity behavior, reduced tobacco use 73% in ninth grade (greater reductions in use for males) and increased health knowledge (including cigarette and drug information) for nine years. Duration of behavioral changes: Six years. Contact: American Health Foundation, 675 Third Avenue, 11th Floor, New York, NY 10017. 212/551-2507. www.ahf.org

Decrease the rate of probable cause cases of child abuse and neglect per 1,000 population for children under age of 18.

Although child abuse and neglect cuts across racial and socioeconomic lines, research shows that a disproportionate number of victims come from low-income families with multiple risk factors for abusing/neglecting children (Dorman, et, al., 1999). Poverty is the most frequently and unremittingly noted risk factor for child abuse (Betha, 1999). Additional risk factors include unintended pregnancy, parental alcohol/substance abuse, teen parenthood, unrealistic expectations of the child, heavy child care responsibility, inadequate experience in parenting, domestic violence, having a negative attitude toward parenting, parents having been abused themselves, inadequate social supports, and having children with disabilities.

While we do not have the empirical knowledge and methods to prevent all forms of child abuse, research evidence points to prevention models (such as nurse home visiting) that have promising effects.

Systems Development:

- Collaborate with other agencies and community partners to identify at risk populations and link to needed services.
- Monitor the health status of the community to identify geographic and economic regions that that the potential for child abuse and neglect. Target these areas for services/support.
- Reduce the potential for child abuse and neglect through education and assessment.
- Improve access and availability of services that protect against child abuse and neglect.
- Develop a consistent method by which to identify the population of high-risk infants who would most benefit from public health nurse long term home visitation services.
- Collaborate with ethnic groups and community-based organizations and private providers to address training needs with respect to cultural competency and culture-specific health problems.
- Provide culturally and linguistically appropriate staff, resources, materials and communications for at risk families.
- Participate in teen pregnancy prevention efforts.
- Assure adequate family planning services are provided to populations in need.
- Assist in the development of community-based parenting classes and coordinate the provision of parenting programs.
- Increase the number of school staff/child care staff, health care professionals receiving annual training in identification and reporting of child abuse and neglect.

Decrease the rate of probable cause cases of child abuse and neglect per 1,000 population for children under age of 18. *(Continued)*

Best Practices:

- What Works: Preventing Child Abuse and Neglect in Your Community (March 2000). Describes effective programs, noteworthy programs and promising programs and includes a reference list. www.ahs.state.vt.us/whtwks/wwwChildAbuse.pdf
- Models That Work: Online Database at www.bphc.hrsa.dhhs.gov/databases/mtw/search.cfm
- Child and Family Health Needs Assessment and Recommendations for Public Health, Prevention of Child Abuse and Neglect. Center for Child and Family Health. www.ohd.hr.state.or.us/ccfh/child.pdf (includes references and internet resources)
- Canadian Task Force, Preventative Health Care 2000 Update: Prevention of Child Maltreatment www.cma.ca/cmaj/vol-163/issue-11/1451.htm
- Protective Children from Abuse and Neglect (1998) www.futureofchildren.org
- *The Medical Care Providers' Response*: Reporting child abuse & neglect is EVERYONE'S responsibility. This web site offers an electronic brochure and information on the following areas: What is Child Abuse?; What Type of Parents and Families are at Risk?; Reporting Abuse and Neglect; What to Report; and Patient Relationship. The information is distributed by the Missouri MC+ Health Plans and Behavioral Health Organizations and is intended to be for informational purposes only. To view the brochure online: <http://www.dss.state.mo.us/dms/pages/can.htm>

Decrease the death rate per 100,000 due to unintentional injuries among children aged 1 through 14 years.

According to Healthy People 2010, deaths of children after infancy represent a public health concern and an opportunity for prevention. The leading cause of death for children of all ages is injury:

- Among children aged 1 to 4 years, the leading injury-related causes of death are motor vehicle crashes, drowning, and fires and burns.
- Among those aged 5 to 14 years, the leading causes of death include motor vehicle crashes, firearms (including unintentional deaths, homicides and suicides)
- Twenty-five percent of Americans live in rural areas. Injury related death rates are 40% higher in rural populations than in urban populations.

Unintentional injuries comprise a group of complex problems involving many different sectors of society. No single force working alone can accomplish everything needed to reduce the number of injuries. Improved outcomes require the combined efforts of many fields, including health, education, transportation, law, engineering, and safety sciences.

Systems Development:

- Monitor health status of community to identify geographic and economic regions that have highest incidence of unintentional injuries to children.
- Convene and staff local MCH coalitions to address the needs identified.
- Continually increase the development of partnerships and collaborations between statewide, local, public and private agencies, organizations and providers to organize health promotion activities/programs on topics of special interest and local concern related to unintentional injuries.
- Provide MCH leadership in the development of non-biased, culturally appropriate health promotion messages and materials related to unintentional injuries.
- Encourage the local media to publicize health promotion activities related to unintentional injuries.
- Establish ongoing linkages with public safety, law enforcement transportation, schools and others regarding safety.

Best Practices:

- The Guide to Community Preventative Services (the Community Guide) will provide public health decision makers with recommendations regarding population based interventions to promote health and to prevent disease, injury, disability and premature death, appropriate for use by communities and health care systems. www.thecommunityguide.org

The motor vehicle Occupant Injury Prevention chapter addresses the following questions:

- What community-based interventions increase the proper use of child safety seats?
 - What community-based interventions increase the use of seat belts?
 - What community-based interventions decrease the occurrence of alcohol-impaired driving?
- See recommendations for interventions to reduce motor vehicle occupant injury at www.cdc.gov/mmwr/PDF/rr/rr5007.pdf
 - The David and Lucile Packard Foundation, Unintentional Injuries in Childhood, (Spring/Summer 2000). The Future of Children, Vol. 10. www.futureofchildren.org

Decrease the death rate per 100,000 due to unintentional injuries among children aged 1 through 14 years. *(Continued)*

- Youth Violence: A Report of the Surgeon General. The Surgeon General's Report on youth violence provides a review of what we know about youth violence from a public health perspective, summarizing the state of the science on youth violence and prevention. A copy of the report is available from the Knowledge Exchange Network, PO Box 42490, Washington, D.C., 20015, Phone orders may be placed to 1-800-789-2647, Monday through Friday, 8:30 a.m. to 5:00 p.m., EST. To view the full document on line, go to www.mentalhealth.org/youthviolence/surgeongeneral/SG_Site/home.asp

Decrease the rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.

The leading cause of death for children ages 1-14 is motor vehicle crashes (Healthy People 2010). Motor vehicle crashes are often predictable and preventable. Increased use of safety belts and reductions in driving while impaired are two of the most effective means to reduce the risk of death and serious injury of occupants in motor vehicle crashes.

Systems Development:

- Monitor health status of community to identify geographic and economic regions that have highest incidence of unintentional injuries to children.
- Convene and staff local MCH coalitions to address the needs identified.
- Continually increase the development of partnerships and collaborations between statewide, local, public and private agencies, organizations and providers to organize health promotion activities/programs on topics of special interest and local concern related to unintentional injuries.
- Provide MCH leadership in the development of non-biased; culturally appropriate health promotion messages and materials related to unintentional injuries.
- Encourage the local media to publicize health promotion activities related to unintentional injuries.
- Establish ongoing linkages with public safety, law enforcement transportation, schools and others regarding safety.

Best Practices:

- The Guide to Community Preventative Services (the Community Guide) will provide public health decision makers with recommendations regarding population-based interventions to prevent motor vehicle occupant injuries. www.thecommunityguide.org

The motor vehicle Occupant Injury Prevention chapter addresses the following questions:

- What community-based interventions increase the proper use of child safety seats?
 - What community-based interventions increase the use of seat belts?
 - What community-based interventions decrease the occurrence of alcohol-impaired driving?
- See recommendations for interventions to reduce motor vehicle occupant injury at www.cdc.gov/mmwr/PDF/rr/rr5007.pdf
 - The David and Lucile Packard Foundation, Unintentional Injuries in Childhood, (Spring/Summer 2000). The Future of Children, Vol. 10. www.futureofchildren.org

Decrease the rate of suicide deaths among youths ages 15-19.

Adolescent suicide is an important public health problem. Each year in the United States, between 2000 and 2500 adolescents under the age of 20 commit suicide. Almost twice as many adolescents commit suicide than die from all natural causes combined. Adolescent suicide prevention is therefore an important goal, which is most likely to be achieved by a better understanding of risk factors and how and when they operate.

The most significant threats to the health of today's adolescents are behavioral in nature and related to psychosocial risks rather than natural causes.

Mental health and substance use are intrinsically related to the common cluster of adolescent mortalities and morbidity's (motor vehicle injuries and fatalities, suicide, violence, and unintentional pregnancies).

Systems Development:

- Monitor health status of community to identify geographic and economic regions that have highest incidence of suicide.
- Convene and staff local MCH coalitions to address the needs identified
- Educate professionals and the community to recognize suicidal ideas and behaviors in adolescents, respond appropriately, and make referrals to treatment and necessary support.
- Continually increase the development of partnerships and collaborations between statewide, local, public and private agencies, organizations and providers to organize health promotion activities/programs on topics of special interest and local concern related to suicide.
- Provide MCH leadership in the development of non-biased; culturally appropriate health promotion messages and materials related to suicide.
- Encourage the local media to publicize health promotion activities related to suicide.
- Establish ongoing linkages with public safety, law enforcement transportation, schools and others regarding safety.
- Work with other to identify culturally, linguistically, economically or geographically isolated individuals at risk and link to care.
- Collaborate with ethnic groups, community based organizations, and private providers to address the training needs with respect to cultural competency and culture specific interventions related to mental health.
- Work with others to develop and disseminate community resource directories/hot line information for teens. Ensure translation of information into other languages, if appropriate.
- Participate on advisory committees on local and state related to the mental health needs of adolescents.

Decrease the rate of suicide deaths among youths ages 15-19. *(Continued)*

Best Practices:

- The Guide to Community Preventative Services (the Community Guide) will provide public health decision makers with recommendations regarding population-based interventions to promote health and to prevent disease, injury and disability, and premature death, appropriate for use by communities and health care systems. The Prevention of Depression and the Occurrence of Depression with other Mental and Physical Conditions will summarize the published evidence of population-based interventions that have been used in communities to promote prevention, early detection, and screening. **Anticipated Date of Publication:** Spring 2003. For information: www.thecommunityguide.org
- Promotion of Adolescent Mental Health and Prevention of Substance Abuse. Prepared by the Oregon Health Division, September 2000. www.ohd.hr.state.or.us/ccfh/adol.pdf
- Knowledge Path: Adolescent Violence Prevention. The National Center for Education in Maternal Child & Family Health. May 2001. www.ncemch.org/RefDes/kpadolvio.html
- Methods of Adolescent Suicide Prevention
www.psychiatrist.com/supplement/v60s02/60s0214.htm
- The Oregon Plan for Youth Suicide Prevention. Prepared by the Oregon Health Division, December 2000. www.ohd.hr.state.or.us/ipe/2000plan/action.pdf
- Russell, S. and Joyner, K (2001). Adolescent Sexual Orientation and Suicide Risk: Evidence From a National Study. American Journal of Public Health, 91(8), 1276-1281.
- Mental Health of Children: www.ukans.edu/~karpwit/Public Ed.htm
- The National Adolescent Health Information Center (NAHIC) serves as a national resource for adolescent health research and health-related information. University of California, San Francisco, School of Medicine, Division of Adolescent Medicine, Department of Pediatrics and Institute of Health Policy Studies, UCSF Box 0503, San Francisco, CA 94143.
youth.ucsf.edu/nahic Information and Fact Sheets available:

Adolescent Demographic	Investing in Preventive Health Services for Adolescent
Adolescent Homicide	Adolescent HealthCare Utilization
Adolescent Mortality	Adolescent Pregnancy Prevention: Effective Strategies
Adolescent Sexuality	Adolescent Substance Abuse
Adolescent Suicide	

Strategies:

- Educate professionals and the community to recognize suicidal ideas and behaviors in adolescents, respond appropriately, and make referrals to treatment and necessary support.
 - Provide community and professional education about indicators for depression and suicidal behaviors in youth
 - Include educators, public and private health care providers, social service providers, youth workers, and the faith community
- Facilitate access to crisis and mental health programs and support services
 - Assess community efforts toward meeting youth mental health needs
 - Assess policies and community norms that support help-seeking and recovery
 - Involve all community stakeholders in designing prevention approaches
 - Disseminate information regarding crisis hot lines available to adolescents.
 - Develop a community "yellow pages" for adolescents.
 - Maintain current mental health referral information

Decrease the rate of suicide deaths among youths ages 15-19. *(Continued)*

- Serve on local school health advisory council to advocate for preventive mental health programs
- Develop a community-based initiative for Children's Mental Health Month in conjunction with the Department of Mental Health
- Develop grassroots support for the development of interventions through the Injury Control Advisory Committee located in the Department of Health
- Promote a comprehensive data collection system
 - Analyze data to evaluate interventions and community policies
 - Track indicators
 - Disseminate information to the public, schools and organizations on suicide indicators and rates
- Promote and support relationship models and healthy coping
 - Teach caregivers about child and youth development
 - Promote parent support groups, youth peer support groups
 - Model healthy relationships through mentoring
 - Encourage use of interventions such as School Conflict Resolution and Yellow Ribbon Program
- Promote and enforce restrictions to common means of suicide
 - Promote safe storage of firearms and ammunition
 - Encourage use of trigger locks
 - Encourage safe storage of medications
 - Encourage families to use a home safety checklist
 - Provide anticipatory guidance to parents of adolescents regarding guns in the home
 - Develop a community-based campaign regarding gun safety for children and adolescents

Section 4: Scope of Work for MCH Contract

SCOPE OF WORK

MATERNAL CHILD HEALTH - TITLE V CONTRACT

October 1, 2002 - September 30, 2003

1.0 Purpose

- 1.1 To establish an integrated multi-tiered service coordination system (direct, population-based, infrastructure) capable of adapting to address targeted maternal-child health issues.

2.0 Deliverables

- 2.1 The Contractor shall execute the approved plan of work (Exhibit 1).
- 2.2 The Contractor shall comply with all terms and conditions set forth in the Program Guidance for FFY 2003 Maternal and Child Health contracts.

3.0 Reports

- 3.1 The Contractor shall submit reports using the forms and/or formats specified by the Department.
 - 3.1.1 The Contractor shall report quarterly on progress toward milestones outcomes in the plan of work.
 - 3.1.2 The Contractor shall report annually on progress toward short-term outcomes in the plan of work.
 - 3.1.3 The Contractor shall report quarterly, the total cost incurred in meeting the outcomes in the plan of work.
- 3.2 Quarterly reports shall be received by the last day of the months of January, April, July, and October.
- 3.3 The annual report for the contract year shall be received by thirty days (30) following the end of the contract period (October 30th).

4.0 Invoicing and Payments

- 4.1 The contractor shall submit to the Department uniquely identifiable invoices for payment processing using the Vendor Request For Payment (DH-38). Uniquely identifiable means the particular invoice or bill can be distinguished by invoice number from a previously submitted invoice.
- 4.2 The Contractor shall invoice the Department for one-twelfth of the total award amount by the last day of the month following each contract month.
- 4.3 The Department shall have no obligation to pay any invoice submitted after the due date.
- 4.4 The Contractor shall be assured to receive the full award amount during the FFY 2003 contract providing good faith efforts are documented subject to availability of funds as in accordance with paragraph seventeen (17) of the Program Services Contract (DH70).
- 4.5 The Contractor and the Department shall follow the MCH Outcome Funding Plan for FFY 2003 and successive contract years as described in the Program Guidance for Maternal and Child Health contracts.

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- 4.5.1 The Contractor shall complete all annual short-term outcomes in order to retain all provisional funds as defined in the Program Guidance for FFY 2003 Maternal and Child Health contracts.
- 4.5.2 The Department shall reduce funding based on the negotiated condition for each short-term outcome not completed by the Contractor.
 - 4.5.2.1 The negotiated condition for each short-term outcome shall be no lower than five percent of provisional funds.
 - 4.5.2.2 The Contractor may choose to have any reduction made from the final annual contract payment, or may choose to have the reduction made from the award amount for the following contract year.
 - 4.5.2.3 In the event the Contractor does not participate in the following year, and the final contract payment is less than the amount to be reduced, the Contractor will issue a check for the difference made payable to "DHSS-DOA-Fee Receipts" and shall mail the payment to:

Missouri Department of Health and Senior Services
Division of Administration
Fee Receipts
PO Box 570
920 Wildwood Drive
Jefferson City, MO 65102-0570

- 4.6 Beginning in FFY 2004 the Contractor shall be eligible for an Incentive Award after participation in the contract for three successive years based on the following conditions:
 - 4.6.1 The Contractor's Performance Measure Targets shall not have changed during the previous three years.
 - 4.6.2 The Contractor shall meet or exceed the Performance Measure Targets.
 - 4.6.3 Award of incentive funds will be based on availability of funds available to the Department.

- 4.7 If the Contractor was overpaid by the Department, the Contractor will issue a check made payable to "DHSS-DOA-Fee Receipts" and shall mail the payment to:

Missouri Department of Health and Senior Services
Division of Administration
Fee Receipts
PO Box 570
920 Wildwood Drive
Jefferson City, MO 65102-0570

5.0 Monitoring

- 5.1 The Department reserves the right to monitor this contract on-site at a minimum of once a year.

- 5.2 Department Staff will monitor to see that the Contractor is in compliance with the plan of work.
 - 5.3 The Department reserves the right to request an audit performed in accordance with generally accepted auditing standards at the expense of the Contractor at any time contract monitoring reveals such audit is warranted.
 - 5.4 The Contractor is responsible for keeping and making available to the Department staff all books, records and documentation for audit and monitoring purposes during the contract period and for a period of three (3) years after final payment or the completion of an audit, whichever is later.
- 6.0 Special Provisions
- 6.1 The length of the contract shall be one year with the option of two additional one-year renewal periods, if requested by the Contractor and approved by the Department.
 - 6.1.1 The Contractor shall supply a plan of work for at least two consecutive years in order to qualify for the renewal option.
 - 6.1.2 Award for funding for years two and three is predicated on the availability of funds and the Contractor's satisfactory performance in the previous year contract.
 - 6.2 The Contractor shall attend an entire contract-opening meeting held in a district office.
 - 6.3 The Contractor may request to amend the approved plan of work during the contract year by submitting, on agency letterhead, the reason for the requested change(s), and the revised plan.
 - 6.3.1 The Contractor shall submit amendment requests six months prior to the expiration of the contract.
 - 6.3.2 The Contractor may substitute short-term outcomes in the amended plan of work that are of equal value to the original short-term outcomes.
 - 6.3.3 Requested amendments may be approved, modified, or rejected by the Department in accordance with the MCH Program Guidance.
 - 6.4 The Contractor shall develop and implement a written plan for continuous quality improvement as described in the MCH Program Guidance.
 - 6.5 The Department shall assess the Contractor for placement on the Conditional Contractor List.
 - 6.5.1 Effective in FFY 2003 and successive years, the Contractor shall be placed on the Conditional Contractor List if one or more annual short-term outcomes are not met, or all quarterly and annual reports and all invoices are not submitted by the contract deadline, or the Contractor does not attend a district meeting to open the contract.
 - 6.5.2 Effective in FFY 2005 and successive years, the Contractor shall be placed on the Conditional Contractor List if during the previous three contract years, no positive change has occurred in the Performance Measure Targets for all the priority problem areas identified on the MCH Performance Reference.

- 6.6 The Contractor may be granted conditional contractor status for one contract year after placement on the Conditional Contractor List.
- 6.7 The Department may remove the conditional contractor status based on Contractor performance.
 - 6.7.1 The Department may remove the conditional contractor status if, during the conditional year the Contractor achieves all annual short-term outcomes, and all quarterly and annual reports and all invoices are submitted by the contract deadline, and the Contractor attends a District meeting to open the contract.
 - 6.7.2 The Department may remove the conditional contractor status if, during the conditional year positive change has occurred in the Performance Measure Targets for the priority problems areas identified on the MCH Performance Reference or as negotiated.
- 6.8 The Department reserves the right to request competitive proposals in any service area for reasons to include, but not be limited to:
 - a. Unsatisfactory Contractor performance.
 - b. Contractor's affirmative response of intent not to contract.
 - c. Contractor's failure to respond with intent to contract for the following contract year.
- 6.9 The Contractor agrees that funds provided by the Department may not be used in any manner to replace or supplant state or federal funds for any service included in this contract. Funds shall be used to expand or enhance MCH activities. For payments under this contract, the Department shall be viewed as the payer of last resort.
- 6.10 Funding under this contract shall not be expended for the purpose of performing, assisting, or encouraging abortion, and none of these funds shall be expended to directly, or indirectly, subsidize abortion services.
- 6.11 Funding under this contract shall not be expended for the purpose of providing comprehensive family planning services.
- 6.12 Individuals with income falling below one hundred percent (100%) of the federal poverty guidelines shall not be charged for services under this contract. Poverty guidelines are published annually by the U. S. Department of Health and Human Services.
- 6.13 The Department reserves the right to unilaterally approve changes on any Department-supplied contract reporting forms and formats.
- 6.14 The Department reserves the right to determine the method of distribution for any unawarded Maternal and Child Health Services Contract funds.
- 6.15 Any equipment purchased by the Contractor under the terms of this contract shall be the property of the Contractor